
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) TRANSITION WAIVER

Provider Policy & Procedure Manual



**The State of Indiana:
Office of Medicaid Policy and Planning
Division of Mental Health and Addiction**

This manual is an authorized reference document for the Indiana Medicaid PRTF Transition Waiver providers and the administration of the Waiver program.

New: October 1, 2012

Address any comments concerning the contents of this manual to:

Office of Medicaid Policy and Planning
Attn: Korryn Fairman
402 W. Washington St., Room W374, MS 07
Indianapolis, IN 46204-2739

Division of Mental Health and Addiction
Attn: Rebecca Buhner
402 W. Washington St., Room W353, MS 15
Indianapolis, IN 46204-2739
317-232-7800
Fax: 317-233-1986

TABLE OF CONTENTS

| | |
|--|----|
| Section 1: PURPOSE OF THE PROVIDER MANUAL..... | 8 |
| SECTION 2: PRTF TRANSITION WAIVER OVERVIEW..... | 9 |
| Goals | 9 |
| Objectives | 9 |
| Organizational Structure | 10 |
| Service Delivery Methods | 10 |
| Providers | 10 |
| Quality Management..... | 10 |
| SECTION 3: PROVIDER CERTIFICATION, RE-CERTIFICATION & TRAINING | 12 |
| Provider Certification Policy | 12 |
| Service Provider Certification Procedures..... | 13 |
| Seriously Emotionally Disturbed (SED) Experience Requirement | 19 |
| Provider Training & DMHA Certifications..... | 20 |
| Service Provider Recertification Policy | 22 |
| Individual Service Provider Transfer to an Existing Agency..... | 27 |
| Licensed Foster Parents as Providers..... | 28 |
| SECTION 4: PROVIDER AGREEMENT & EXPECTATIONS..... | 29 |
| IHCP Provider Agreement..... | 29 |
| Provider Record Updates..... | 29 |
| Solicitation Policy | 31 |
| Professional Code of Conduct and Service Delivery Expectations | 33 |
| SECTION 5: DPCI, EMTA TOPM STANDARDS & GUIDELINES | 35 |
| Maintenance & Submission of Documentation Files..... | 35 |
| Standard Content for All Documentation | 36 |
| Monthly Status Reports | 37 |
| SECTION 6: CLAIMS & BILLING OVERVIEW | 38 |
| Eligibility Impact on Billing | 38 |
| Waiver Services Authorization | 39 |
| Billing Instructions | 40 |
| Billing Units of Service | 40 |
| Claim Tips & Reminders | 42 |
| Claim Voids & Replacements..... | 43 |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | |
|---|----|
| SECTION 7: PROVIDER SUPPORT | 44 |
| Quality Improvement Specialists Support..... | 44 |
| Website..... | 44 |
| Medicaid Provider Support..... | 44 |
| SECTION 8: UTILIZATION REVIEW AND QUALITY MANAGEMENT | 45 |
| Surveillance Utilization Review & Provider Audits | 45 |
| Level of Care Re-Evaluation & Review of Participant Service Plans | 46 |
| Financial Integrity Audits | 47 |
| Quality Improvement Strategy..... | 48 |
| SECTION 9: PARTICIPANT ELIGIBILITY | 49 |
| Target Group | 49 |
| Service Authorization | 49 |
| Continued Eligibility for Waiver Services | 49 |
| CANS Assessment & Level of Care | 50 |
| LOC Review & Evaluation..... | 51 |
| Participant Termination, Interrupt, Re-Start and Re-Entry Status | 52 |
| Participant Transition from Waiver Services..... | 54 |
| Medicaid Eligibility & Service Delivery..... | 54 |
| SECTION 10: WRAPAROUND SERVICE DELIVERY OVERVIEW | 56 |
| The Child & Family Wraparound Team | 57 |
| The Four Stages of the Wraparound Process | 58 |
| Wraparound Fidelity Index | 59 |
| Service Plan Implementation & Monitoring..... | 59 |
| SECTION 11: PLAN OF CARE | 61 |
| Individualized Plan of Care Policy | 61 |
| Participant Freedom of Choice Policy | 62 |
| Plan of Care Development Process and Guidelines | 62 |
| DMHA Authorization of Plan of Care | 66 |
| Service Delivery & Plan of Care | 67 |
| SECTION 12: CRISIS PLAN | 69 |
| Crisis Plan Development..... | 69 |
| Maintenance of the Crisis Plan..... | 70 |
| SECTION 13: WRAPAROUND FACILITATION SERVICE..... | 71 |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | |
|---|----|
| Description of Service Code & Billing Information* | 71 |
| Wraparound Facilitation Services Definition | 71 |
| Wraparound Facilitator- Provider Qualifications & Standards | 72 |
| Activities Allowed | 73 |
| Activities Not Allowed | 74 |
| Service Delivery Standards | 74 |
| Documentation Requirements | 75 |
| Billing Instructions | 77 |
| SECTION 14: WRAPAROUND TECHNICIAN SERVICE | 78 |
| Description of Service Code & Billing Information* | 78 |
| Wraparound Technician Services Definition | 78 |
| Wraparound Technician Provider Qualifications and Standards | 78 |
| Activities Allowed | 80 |
| Activities Not Allowed | 80 |
| Service Delivery Standards | 81 |
| Documentation Requirements | 81 |
| Billing Instructions | 81 |
| SECTION 15: HABILITATION SERVICE | 82 |
| Description of Service Code & Billing Information* | 82 |
| Habilitation Service Definition | 82 |
| Provider Qualifications and Standards | 82 |
| Activities Allowed | 85 |
| Activities Not Allowed | 85 |
| Service Delivery Standards | 86 |
| Documentation Requirements | 86 |
| Billing Instructions | 86 |
| SECTION 16: RESPITE CARE SERVICE | 87 |
| Description of Service Code & Billing Information* | 87 |
| Respite Care Service Definition | 88 |
| Provider Qualifications and Standards | 89 |
| Requirements for Family Member as Respite Provider | 91 |
| Activities Allowed | 91 |
| Activities Not Allowed | 92 |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | |
|---|-----|
| Service Delivery Standards..... | 92 |
| Documentation Requirements..... | 93 |
| Billing Instructions..... | 93 |
| SECTION 17: CONSULTATIVE CLINICAL & THERAPEUTIC SERVICE | 94 |
| Description of Service Code & Billing Information* | 94 |
| Consultative Clinical and Therapeutic (CCT) Services Definition | 94 |
| CCT Provider Qualifications and Standards | 95 |
| Activities Allowed | 96 |
| Activities Not Allowed..... | 96 |
| Service Delivery Standards..... | 96 |
| Documentation Requirements..... | 96 |
| Billing Instructions..... | 97 |
| SECTION 18: FLEXFUND SERVICE | 98 |
| Description of Service Code & Billing Information* | 98 |
| Flex Funds Service Definition..... | 98 |
| Provider Qualifications and Standards | 98 |
| Activities Allowed | 99 |
| Activities Not Allowed..... | 99 |
| Service Delivery Standards..... | 100 |
| Documentation Requirements..... | 101 |
| Billing Instructions..... | 101 |
| SECTION 19: NON-MEDICAL TRANSPORTATION SERVICE | 102 |
| Description of Service Code & Billing Information* | 102 |
| Non-Medical Transportation Services Definition..... | 102 |
| Provider Qualifications and Standards | 102 |
| Activities Allowed | 104 |
| Activities Not Allowed..... | 104 |
| Service Delivery Standards..... | 105 |
| Documentation Requirements..... | 105 |
| Billing Instructions..... | 105 |
| SECTION 20: TRAINING & SUPPORT FOR UNPAID CAREGIVER SERVICE..... | 106 |
| Description of Service Code & Billing Information* | 106 |
| Training and Support for Unpaid Caregiver Service Definition..... | 107 |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | |
|---|-----|
| Provider Qualifications and Standards | 107 |
| Activities Allowed | 109 |
| Activities Not Allowed..... | 109 |
| Service Delivery Standards..... | 109 |
| Documentation Requirements..... | 109 |
| Billing Instructions..... | 110 |
| SECTION 21: CRITICAL EVENTS & INCIDENTS | 111 |
| Overview of Expectations..... | 111 |
| Incident Reporting Policy | 112 |
| SECTION 22: GRIEVANCE OR COMPLAINTS..... | 113 |
| Grievance or Complaint Reporting Policy..... | 113 |
| SECTION 23: GLOSSARY..... | 114 |

SECTION 1: PURPOSE OF THE PROVIDER MANUAL

The purpose of this manual is to provide a reference document for service delivery under the Medicaid-approved home and community-based Wraparound services provided through the Psychiatric Residential Treatment Facility (PRTF) Transition Waiver. The manual provides information and instruction for:

- 1) All DMHA-certified Wraparound facilitators and service providers;
- 2) State staff who administer, manage, and oversee Indiana's PRTF Transition Waiver program; and
- 3) Entities interested in applying to become service providers for the PRTF Transition Waiver.

The Provider Policy and Procedure Manual not only outlines program expectations, policies and procedures, but also provides useful guidelines and resources for those providing services under the PRTF Transition Waiver.

NOTE: All amendments to the Waiver Program and/or provider manual are binding upon receipt or publication. Receipt of all information is presumed when mailed to the billing provider's current Mail to address on file with Division of Mental Health and Addiction (DMHA), Indiana Family Social Service Administration (IFSSA) and the Medicaid fiscal agent.

Additional reference sites and resources for the PRTF Transition Waiver service providers and Participants/families enrolled under the waiver include:

- 1) IHCP website: <http://provider.indianamedicaid.com/news.-bulletins.-and-banners.aspx> and
- 2) The DMHA website: <http://www.in.gov/fssa/dmha/6643.htm>.

SECTION 2: PRTF TRANSITION WAIVER OVERVIEW

The PRTF Transition Waiver is a result of the 5-year implementation of the Community Alternative to Psychiatric Residential Treatment Facility (CA-PRTF) Demonstration Grant. Regarding the CA-PRTF Demonstration Grant, Section 6063 of the Deficit Reduction Act (DRA) of 2005 specifies:

“At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.”

As a result, the 1915(c) Psychiatric Residential Treatment Facility (PRTF) Waiver is **solely for the transition of eligible children and youth** from CA-PRTF Grant services to PRTF Transition Waiver services, following the expiration of the Demonstration Grant on September 30, 2012.

The PRTF Transition Waiver will continue to promote Indiana’s behavioral health system transformation, to provide intensive community-based care for youth with high levels of need whose family/caretaker and community would be able and willing to safely maintain the youth in a community-based setting with adequate and appropriate interventions and support.

GOALS

Indiana’s fundamental transformation goal continues to ensure that youth in community settings receive effective behavioral health services and support at the appropriate level of intensity, based on their needs and the needs of their families. This Waiver maintains the re-balancing of resources between PRTF/SOF and intensive community-based services for children with serious emotional disturbances (SED)/youth with serious mental illness (MI). The Waiver provides a means for:

- 1) Offering specific services designed to reduce the need for out-of-home placements to support children with SED/youth with serious MI;
- 2) Controlling financial risk for those youth who meet the Psychiatric Residential Treatment Facility (PRTF)/State Operated Facility (SOF) level of care;
- 3) Supporting the development of service providers guided by the Wraparound principles and values; and
- 4) Bringing all agencies who serve youth together through a System of Care, to assist youth and families within their community.

Note: The only youth eligible to receive PRTF Transition Waiver services are Participants enrolled in the CA-PRTF Demonstration Grant, as of September 30, 2012.

OBJECTIVES

As authorized under Section 6063 of the DRA of 2005, the PRTF Waiver allows Indiana to transition all eligible children/youth from the CA-PRTF Grant to the PRTF Transition Waiver effective October 1, 2012.

Participants are Medicaid-eligible youth, ages 6 through 20, who continue to meet the eligibility requirements for admission to a PRTF/SOF and who were enrolled in the CA-PRTF Grant as of September 30, 2012. Due to the limitation imposed by the DRA of 2005 for this transition waiver, no additional individuals will be allowed to apply for or receive waiver services through this PRTF Transition Waiver.

ORGANIZATIONAL STRUCTURE

Indiana's Division of Mental Health and Addiction (DMHA) was originally given the authority by The Office of Medicaid Policy and Planning (OMPP) to administer the CA-PRTF Demonstration Grant--and will continue to administer the PRTF Transition Waiver. The Waiver application and the design have been jointly developed by DMHA and OMPP. OMPP will oversee all executive decisions and activities related to the Waiver.

SERVICE DELIVERY METHODS

Indiana uses a traditional service delivery method rather than a self-directed one. Intensive community-based, wraparound services are managed and provided through Child and Family Teams, under the guidance of System of Care (SOC) values and principles.

The following waiver services, previously provided in the CA-PRTF Demonstration Grant, continue to be available to eligible youth under the PRTF Transition Waiver:

- 1) Wraparound Facilitation
- 2) Wraparound Technician
- 3) Habilitation
- 4) Respite Care
- 5) Consultative Clinical and Therapeutic Services
- 6) Flex Funds
- 7) Non-Medical Transportation
- 8) Training and Support for Unpaid Caregivers

All service plans of care must be approved by DMHA before services are accessed. And, DMHA-approved waiver service providers will bill Medicaid for services provided to eligible Participants on the CMS 1500 claim form through the traditional Medicaid claims processing system.

PROVIDERS

All CA-PRTF Demonstration Grant service providers, meeting specific standards set forth by DMHA became PRTF Transition Waiver providers on October 1, 2012. Refer to Manual Section 3: *Provider Certification, Re-Certification & Training Requirements* for additional information and the requirements for transition of Providers from CA-PRTF Demonstration Grant to PRTF Transition Waiver service delivery.

As needed, to support this limited waiver program, additional child service agencies and providers may continue to be recruited to become waiver service providers. All DMHA-approved waiver service providers must meet specific criteria and standards for providing the waiver services; complete the DMHA certification application process; acquire a Medicaid IHCP provider number; and complete all DMHA-mandated training. Refer to Manual Section 3: *Provider Certification, Re-Certification & Training Requirements* for additional information.

QUALITY MANAGEMENT

Indiana's quality management process for the PRTF Transition Waiver includes monitoring, discovery and remediation processes implemented to identify opportunities for ongoing quality improvement within the program—and to ensure the waiver is operated as follows:

- 1) In accordance with federal and state requirements;

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 2) To ensure Participant health and welfare;
- 3) To ensure Participant needs, goals and preferences are part of the person-centered planning process and reflected in the Plan of Care.

Refer to Manual Section 8: *Utilization Review and Quality Improvement* for additional information.

SECTION 3: PROVIDER CERTIFICATION, RE-CERTIFICATION & TRAINING

All DMHA-certified CA-PRTF Demonstration Grant service providers (as of September 30, 2012) automatically became a PRTF Transition Waiver service provider (on October 1, 2012), without any additional documentation requirements, as long as the following criteria were met:

- 1) Provider was current and up-to-date with all certification requirements;
- 2) Provider was current and up-to-date with all DMHA-required trainings;
- 3) Provider was considered in “*good standing*” (*Good standing* is defined as having no open or pending investigations, incidents or complaints through FSSA or Department of Child Services); and
- 4) Provider status was Active, and not *Suspended*, *Terminated* or *Closed*.

As needed, to support this limited waiver program, additional child service agencies and providers in areas of need may continue to be recruited to become PRTF Transition Waiver service providers. Prospective service providers must complete the Provider Application and Certification processes, as defined in this section.

PROVIDER CERTIFICATION POLICY

To ensure that providers, initially and continually, meet required licensure and/or certification requirements prior to furnishing waiver services, the following Policy for Provider Certification is in effect:

- 1) Waiver services are provided to eligible Participants by DMHA-approved service providers, which include the following types of behavioral health service providers (Refer to *Provider Application* subsection below for provider type definitions and requirements specific to each waiver service):
 - a) An Accredited Agency;
 - b) A Non-Accredited Agency; or
 - c) An Individual provider.
- 2) Waiver service providers are authorized/certified by DMHA and OMPP to provide one or more of the PRTF Transition Waiver services, as determined by their qualifications and application for certification.
- 3) All applicants wishing to enroll as a waiver service provider must:
 - a) Complete the Provider application.
 - b) Submit documentation supporting that Provider/Agency meets all qualifications and service-specific standards for the service(s) they are applying to become a provider.
 - c) Complete and submit proof of the following screens:
 - i) Finger-print based national and state criminal history background screen;
 - ii) Local law enforcement screen;
 - iii) State and local Department of Child Services abuse registry screen; and
 - iv) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1).

Note: For purposes of this manual, “*Certification*” means the applicant is approved by DMHA as a PRTF Transition Waiver service provider. This “*certification*” refers solely to provider enrollment in the PRTF Transition Waiver program.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 4) DMHA will review the provider application and documentation to determine if the applicant meets the criteria for being certified as a waiver service provider.
- 5) Providers meeting criteria and receiving a DMHA certification approval letter must also apply to OMPP for a Medicaid IHCP provider number before they begin providing and billing for waiver services.
- 6) If OMPP denies the Provider/Agency request for an IHCP provider number, then the Provider/Agency will not be authorized to provide or bill for any waiver service.
- 7) DMHA-approved waiver service providers must adhere to the following:
 - a) Complete DMHA-approved provider training, as required for the service(s) they are authorized to provide.
 - b) Renew the waiver services provider certification, according to the following schedule:
 - i) Accredited agencies reapply for certification every 3 years from the date of original service provider certification. However, if agency undergoes their agency re-accreditation, they must also submit documentation for Provider/Agency re-certification at that time.
 - ii) Non-accredited agencies reapply for certification every 2 years from the date of original service provider certification.
 - iii) Individual providers reapply for certification every 2 years from the date of original service provider certification.
- 8) Providers must adhere to all policy, procedures, standards and qualifications contained in the Policy & Procedure Manual, or any other waiver-related bulletins, or documentation published by DMHA and/or OMPP.
- 9) Provider certification may be revoked under, but not limited to, the following conditions:
 - a) Failure to adhere to and follow all waiver policies and procedures for behavior, documentation, billing and/or service delivery, as defined in the Policy & Procedure Manual, DMHA website and Medicaid's IHCP website/provider manual.
 - b) Failure to respond to or resolve a corrective action imposed upon a Provider/Agency by DMHA/OMPP for non-compliance with waiver policies and procedures.
 - c) Substantiated allegation of abuse or neglect, as determined by the Department of Child Services.
 - d) Failure to maintain clinical qualifications, DMHA-required training/certification, and/or standards required for delivering waiver services the Provider is authorized to provide.
 - e) Failure to apply for Provider re-certification, as defined in the Policy & Procedure Manual.

Note: An Individual or agency provider that has been decertified by any agency under FSSA must wait three (3) years from the date of decertification to reapply as a Provider or Individual. And, the Individual or Provider must show mitigation of issue that caused decertification.

SERVICE PROVIDER CERTIFICATION PROCEDURES

Certification as a PRTF Transition Waiver Provider is service-specific. Each Provider must meet the qualifications and standards for the specific service(s) they wish to provide, as defined in the federally approved PRTF Transition Waiver.

To apply for certification, the Applicant must complete the following application process:

PROVIDER APPLICATION

The Provider Application packet may be found on DMHA's website. Visit the following link for more information: <http://www.in.gov/fssa/dmha/6643.htm>.

Applicants may apply for any service for which they meet the standards and requirements. The table below is a resource to assist applicants understanding the qualifications required to become a certified service provider. Refer to Manual Sections 13-20 for the required criteria and standards for each service under the PRTF Transition Waiver.

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|--|--|--|
| <i>Provider Type Definition</i> | Certified thru DMHA as Community Mental Health Center; or Accredited Community Service Agency | Non-Accredited Community Service Agency | Licensed or unlicensed individual/provider who is not working through another agency |
| <i>Agency Documentation Requirements</i> | Submit a copy of at least one of the following: DMHA-approved accreditation by a nationally recognized accrediting body: AAAHC, COA, URAC, CARF, ACAC, JCAHO, or NCQA DMHA certification as a Community Mental Health Center | Submit a copy of the following: Articles of Incorporation | Not Applicable |
| <i>System of Care Affiliation</i> | For Wraparound Facilitator Agencies: Letter of support signed by local System of Care which includes both a governing coalition and service delivery system that endorses the values and principles of Wraparound. Or, in the event the area | Not Applicable | Not Applicable |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|----------------------------|--|---|--|
| | of the State does not have an organized System of Care, provider is a part of a DMHA-authorized/designated Access Site for services. | | |
| <i>Required Screenings</i> | <p>Agency must maintain documentation that the individual(s) providing a waiver service has completed the following screens and submitted the results:</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen, or Agency meets the same requirements established for Federal Grant recipients specified under 41 U.S.C. 10 Section 702(a)(1). <p><i>See *Note below regarding screenings.</i></p> | <p>Agency must complete and submit a copy of all screening results:</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen, or Agency meets the same requirements established for Federal Grant recipients specified under 41 U.S.C. 10 Section 702(a)(1). <p><i>See *Note below regarding screenings.</i></p> | <p>Complete and submit a copy of all screening results:</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen. <p><i>See *Note below regarding screenings.</i></p> |
| <i>Other Standards</i> | <p>Agency must maintain documentation that the individual(s) providing a waiver service meets the following standards:</p> | <p>Agency must complete and submit a copy of all screening results::</p> <ol style="list-style-type: none"> 1) Current CPR | <p>Submit proof of the following:</p> <ol style="list-style-type: none"> 1) Current CPR certification. |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|--|---|--|
| | 1) Current CPR certification. 2) Maintain on file current documentation at agency demonstrating each individual providing a waiver service(s) meets the service-specific criteria required for each service he/she will be providing. | certification. 2) Maintain on file current documentation at agency demonstrating each individual providing a waiver service(s) meets the service-specific criteria required for each service he/she will be providing. | 2) Current documentation that individual meets service-specific criteria required for each service he/she will be providing. |
| Required Forms | Complete, sign (if required) and submit each of the following forms, which can be downloaded and printed from the DMHA website links provided: 1) <i>Service Provider Certification Form(s)</i> for <u>each</u> service certification is being applied. 2) <i>Provider Demographic Form</i> 3) <i>DMHA Provider Agreement</i> Visit the following link for more information: http://www.in.gov/fssa/dmha/6643.htm . | | |
| Other Documentation | Each PRTF Transition Waiver Service will have its own service-specific documentation that will be required. Submit the additional documentation (if indicated), as defined on each Service Provider Certification Form, for each service provider is applying for certification. Additional information may be located on the DMHA website. Visit the following link for more information: http://www.in.gov/fssa/dmha/6643.htm . | | |
| Submit Provider Application and Documentation to: | PRTF Transition Waiver Provider Specialist Indiana Division of Mental Health and Addiction 402 West Washington Street, Room W353 MS #15 Indianapolis, IN 46204-2739 | | |
| Screenings Note: | | | |
| Drug Screens: Individuals who submit paperwork to become a certified provider under the waiver must complete a 5-Panel Drug Test (THC, Cocaine, Amphetamines/Methamphetamines, Opiates, and PCP). | | | |
| 1) DMHA will only accept urine screens from agencies or places of business that conduct urine screens. The results must be submitted on the agency or place of business letterhead. | | | |
| 2) The Department of Health and Human Services cut-off levels to determine whether the test is | | | |

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|---|-----------------------|-----------------------------|
| | <p>positive or negative will be used.</p> <p>3) A 5-Panel drug screen will not be required if the Agency meets the same requirements as Federal grant recipients specified under 41 U.S.C 10 Section 702(a)(1).</p> <p>4) DMHA will deny all provider applications that test positive for any of the above mentioned drugs.</p> <p>5) Individuals/Providers who are denied will have the right to appeal DMHA's decision.</p> | | |

DMHA REVIEW OF APPLICATION

- 1) Completed applications are processed by DMHA on a first-come first-serve basis.
- 2) If the packet is complete and the provider is eligible, an approval letter is mailed or e-mailed to the provider. The letter directs the eligible provider to contact the Medicaid fiscal agent at *Provider Enrollment* for the IHCP provider application required to complete the Medicaid provider enrollment process. (Refer to instructions below under *Medicaid Provider Enrollment Process*.)
- 3) If the provider does not meet all requirements, the application is denied and the reason is noted on the denial letter mailed to the applicant.
- 4) If the application is incomplete, additional information will be requested in writing by the Provider Specialist. If the additional information is not received by DMHA within 30 days, the application will be considered to be voluntarily withdrawn by the applicant and purged.
- 5) DMHA will disqualify an applicant based on the following criteria:
 - a) Any conviction for a misdemeanor related to the health and safety of a child.
 - b) Any felony conviction.
 - c) Any pending criminal charges.
 - d) The applicant has been convicted of four (4) or more misdemeanors (that are not related to the health and safety of a child).
 - e) The applicant is currently on probation or parole.
 - f) The applicant has been identified as a perpetrator of child abuse or neglect.
 - g) The applicant has a record of substantiated child abuse or neglect
 - h) Provider tested positive for any of the drugs tested for in the 5-Panel drug screen described above.
 - i) Individual or Provider (agency) has been decertified as a provider or breached a contract with any division within FSSA or one of its designees (e.g., Medicaid, DMHA, Division of Aging, Division of Disability and Rehabilitative Services), leading to a termination in contract between the two parties. If an Individual or agency has been decertified by any agency under FSSA, the individual or provider must wait three (3) years from the date of decertification to reapply as a Provider or Individual. And, Individual or Provider must show mitigation of the issue that caused the decertification.

Conditions that will delay processing for both DMHA certification and IndianaAIM enrollment:

- *Any part of the application or attachment(s) is incomplete or illegible.*
- *Any part of the application and/or attachments is inconsistent or unclear (too vague).*
- *The packet is missing a required attachment.*
- *Forms requiring signature are not signed.*
- *The application is not original (Faxed applications will not be accepted).*

- 6) Calls and e-mails from applicants inquiring about the status of their application at DMHA may not receive a response unless there is an issue that requires a response from DMHA. Unless requested to contact DMHA, applicants are asked to refrain from calling DMHA regarding the application status, unless it has been longer than 30 business days since it was mailed.
- 7) When the provider has been successfully enrolled as a Medicaid PRTF Transition Waiver service provider and the provider number is assigned (refer to next section on *Medicaid IHCP Provider Enrollment* process), Medicaid Provider Enrollment notifies DMHA and the new provider is activated in the PRTF Transition Waiver provider database. New providers will be activated on the Friday of the week Medicaid provider enrollment is complete.

MEDICAID IHCP PROVIDER ENROLLMENT

The DMHA certification approval letter directs the eligible provider to contact the Medicaid fiscal agent at "Provider Enrollment" for the IHCP provider application to begin the Medicaid provider enrollment process. The provider applicant must submit the DMHA PRTF Transition Waiver service provider certification approval letter with the IHCP Medicaid provider enrollment application for processing.

The IHCP provider type for the PRTF Transition Waiver is 32, Home and Community Based Services "Waiver Billing" provider.

However, regardless of the status of an applicant's existing enrollment as a current Medicaid provider or provider of one or more of the Medicaid HCBS waiver programs, each provider must be specifically approved by DMHA and enrolled as a provider of the PRTF Transition Waiver in order to be reimbursed for services provided to Participants under this waiver.

The following steps are provided as a resource for applicants enrolling as a Medicaid provider. It is the applicant's responsibility to follow the Medicaid Provider Enrollment process as mandated by IHCP:

- 1) Go to <http://provider.indianamedicaid.com> (or, www.indianamedicaid.com > Provider > Quick Links select "Provider Enrollment") and Launch Enrollment Tool to enroll as a "Waiver Billing" provider (Provider Type = 32 "Waiver", Provider Specialty = 364 "PRTF Transition Waiver"). Enrollment forms may be printed and completed by hardcopy or on-line—and can also be accessed via the Quick Link "Forms".
- 2) Complete Application: When the Medicaid Provider Enrollment department receives the completed IHCP provider application packet, it is processed, and if approved, Medicaid Provider status is given and Provider Enrollment assigns the provider number ("NPI" – national provider identifier/ "LPI" – legacy provider identifier). A provider letter is generated and sent to the provider detailing the assigned IHCP provider billing number and

Helpful Tips for Completing the IHCP Enrollment Application Process:

Business Structure: The application form asks that the provider applicant choose a business structure. The PRTF Transition Waiver provider is enrolled as either a sole practitioner (billing provider), or a group (a group must have members linked to the group), the members linked to the group are called rendering providers and are enrolled as a rendering provider linked to that group. Rendering providers cannot bill for services, the group bills for services identifying the rendering provider as the performer of the service. In order to be a group with members, all of the members must be approved (certified) by the DMHA Provider Specialist.

Social Security Number (SSN) Requirement: Missing or incomplete SSNs will result in the return of the entire enrollment packet. Please refer to 405 Indiana Administrative Code 1-19, Ownership and Control Disclosures.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

enrollment information entered into IndianaAIM. DMHA is notified of the enrollment and provider number.

- 3) Incomplete Application: If the enrollment documents are incomplete, the entire enrollment packet will be returned to the provider with a letter that provides an explanation of the incomplete information. The provider will be required to complete the documentation and return the entire enrollment packet again to IHCP Provider Enrollment.
- 4) Enrollment Application Submission: The enrollment application must be signed and submitted with the requested documentation (W-9, EFT form, Certification letter). To ensure proper processing, all enrollment forms must be directed to the following Medicaid Provider Enrollment address (address is also listed on the application form):

Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

- 5) Enrollment documents are logged into a document tracking system and issued a document tracking number. Medicaid Provider Enrollment has a dedicated staff member assigned to coordinate and handle all waiver provider enrollments and updates. This staff member works closely with IFSSA staff to ensure timely and accurate maintenance of waiver provider issues.
- 6) Provider applicants who have submitted enrollment forms and need assistance may contact the Medicaid Fiscal Agent Provider Enrollment Customer Service Staff (Information is available at www.Indianamedicaid.com or by phone at 1-877-707-5750).
- 7) If a provider applicant has not received a response from Medicaid Provider Enrollment within 30 days, the provider may contact Provider Enrollment at 1-877-707-5750.
Please note: DMHA staff does not have access to Medicaid Provider information regarding the enrollment status until the provider is actually enrolled. DMHA is notified of the enrollment at the same time as the provider.
- 8) If a provider number is not assigned in six (6) months (meaning the provider applicant did not complete the necessary IHCP application process), a letter with a required time frame for response is sent by the PRTF Transition Waiver Provider Specialist to the applicant to ascertain if there is still interest in pursuing the application process. If there is no response within the required timeframe, the applicant is terminated in the waiver provider database.

Note: DMHA staff does not have access to Medicaid Provider enrollment status until the provider is actually enrolled.

Contact Medicaid Provider Enrollment at (877)707-5750 concerning questions about IHCP enrollment status.

SERIOUSLY EMOTIONALLY DISTURBED (SED) EXPERIENCE REQUIREMENT

The requirement of two or three years of experience working with SED children is intended to ensure that providers have the knowledge and understanding of the rewards and challenges of working with the SED population. The amount of SED experience is dependent upon the service an individual wishes to provide (Refer to *Manual Sections 13 through 20* for service specific SED experience requirements).

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

Building functional skills with a child facing impairments associated with an SED diagnosis requires creativity, patience, and sound communication. Therefore, DMHA requires that providers possess demonstrable and direct experience with this demographic.

Qualifying direct experience means that the provider has worked directly with the SED population in a way that builds functional skills, such as group counseling, one on one counseling, provision of skills training, or provision of therapeutic recreational activities. Also included in qualifying direct experience would be persons providing therapeutic foster care, or persons working in a capacity that may not involve mental health care, but where the work is targeted at a defined SED population. Experience in case management, therapy, and/or skills training in conjunction with a mental health center is considered as qualifying experience. Some additional examples of qualifying experience include:

- 1) A teaching or educational assistant working in a classroom where children are enrolled due to SED diagnosis, and where behavioral management and skills training are part of that person's duties.
- 2) A person who is authorized for therapeutic foster care.
- 3) Employee of a residential facility or group home who has responsibility for skills training or counseling beyond standard behavioral and milieu management.

The **experience requirement excludes incidental experience with an SED child or population**. This means that if the work of the provider may have been with a child with SED, but the defined work role was not intended to address this directly, the experience does not qualify towards the requirement. Other examples of incidental experience would include:

- 1) Owning a day care
- 2) Driving a school bus
- 3) Facilitating a youth group or bible school class
- 4) Providing family therapy where some of the children/youth have been classified as severely emotionally disturbed
- 5) Being a classroom teacher
- 6) Working only with the developmentally disabled population
- 7) Experience is working only with children ages 0-5.

One final note, qualifying experience must be recent. This means that the last qualifying experience with SED population should be no more than 3 years in the past. Experience more than 8 years in the past will not be considered as qualifying.

PROVIDER TRAINING & DMHA CERTIFICATIONS

Service providers must complete all DMHA required training and certifications needed to prepare the provider for providing PRTF Transition Waiver services. The following classes and certifications are required, based upon the waiver service(s) he/she is certified to provide:

SERVICE PROVIDER TRAINING

| | DMHA Provider Training | DMHA Provider Certifications |
|------------------------------------|---|--|
| <i>Wraparound Facilitator</i> | <p>SOC and Wraparound 101</p> <p>Wraparound Facilitator Training</p> <p>INsite Training (optional)</p> <p>Any other training, as mandated by DMHA/OMPP</p> | <p>Child and Adolescent Needs and Strengths (CANS) Assessment Tool Super-User Certification</p> <p>Wraparound Practitioner Certification (<i>Enrolled and actively working towards completion of certification according to DMHA mandated timeline</i>)</p> <p>Any other certification, as mandated by DMHA/OMPP</p> |
| <i>Wraparound Supervisor</i> | <p>SOC and Wraparound 101</p> <p>Innovations Institute training in the STEPS Supervisory Tool; and any other DMHA-required Wraparound Supervisory Training</p> <p>Any other training, as mandated by DMHA/OMPP</p> | <p>Child and Adolescent Needs and Strengths (CANS) Assessment Tool Super-User Certification</p> <p>Any other certification, as mandated by DMHA/OMPP</p> |
| <i>Wraparound Technician</i> | <p>SOC and Wraparound 101</p> <p>Waiver Services Provider Training</p> <p>Customized Wraparound Facilitator Training, if covering cases for temporarily absent facilitator.</p> <p>Any other training, as mandated by DMHA/OMPP</p> | <p>Any other certification, as mandated by DMHA/OMPP</p> |
| <i>All Other Service Providers</i> | <p>SOC and Wraparound 101</p> <p>Waiver Services Provider Training</p> <p>Any other training, as mandated by DMHA/OMPP</p> | <p>Any other certification, as mandated by DMHA/OMPP</p> |

CONTINUING EDUCATION REQUIREMENTS

DMHA-certified service providers are required to complete ongoing training and education (CEUs); and provide verification of compliance with this requirement at the time of recertification. CEU requirements are based upon the type of provider certification, as follows:

- 1) *Accredited Agency Providers*: 10 hours of approved trainings/conferences every year for a total of 30 hours (Accredited agencies must be recertified every three years).
- 2) *Non-Accredited Agency Providers*: 10 hours of approved trainings/conferences every year for a total of 20 hours (Non-accredited agencies must be recertified every two years).
- 3) *Individual Service Providers*: 10 hours of approved trainings/conferences every year for a total of 20 hours (Individuals must be recertified every two years).

SERVICE PROVIDER RECERTIFICATION POLICY

Indiana has made certain assurances to the Centers for Medicare and Medicaid Services (CMS) that, in order to receive funding for the waiver, all services providers are qualified to provide the services to waiver Participants. To demonstrate compliance with this federal expectation, DMHA requires providers to periodically submit documentation to demonstrate they continue to meet qualifications and standards required of DMHA-certified waiver service providers.

- 1) All DMHA-certified service providers are responsible to reapply for provider certification according to the following recertification schedule:
 - a) *Accredited Agencies* must be recertified by DMHA at least every three years following their initial certification by DMHA; or at the time of their national agency re-accreditation (which ever date is earlier).
 - b) *Non-Accredited Agencies* must be recertified by DMHA at least every two years following their initial certification by DMHA.
 - c) *Individual Service Providers* must be recertified by DMHA at least every two years following their initial certification by DMHA.
- 2) Providers must submit their documentation for recertification in writing to DMHA at least **60 days** prior to the date of the recertification deadline. This will allow time for DMHA to review the information; contact the provider if there are any questions or additional information is required; and complete the recertification prior to the deadline.
- 3) It is the responsibility of the service provider/agency to track the due date of their recertification. DMHA will send past due letters to providers/agencies that are out of compliance with the recertification requirement.
- 4) Failure to comply with these recertification requirements in a timely manner will result in the provider being placed on *Suspended status* pending the completion of the DMHA recertification process. Suspended status means:
 - a) The provider's name will no longer appear on the provider pick list as a qualified PRTF Transition Waiver service provider in any county.
 - b) The provider may continue to provide services to those Participants the provider is currently serving. However, the provider is prohibited from accepting any new Participants.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- c) Upon receipt and approval by DMHA of recertification paperwork, the provider status will be updated to *active*.
 - d) Continued failure to comply with recertification requirements will result in decertification as a provider of PRTF Transition Waiver services.
- 5) Under 405 IAC 1-1-6, if a provider has violated any rule established under IC 12-15, the Office of Medicaid Policy and Planning may impose one or more of the following sanctions:
- a) Deny payment;
 - b) Decertify the provider;
 - c) Assess a fine;
 - d) Assess an interest charge; or
 - e) Require corrective action against the agency/provider.
- 6) DMHA will disqualify a service provider based upon on the following criteria:
- a) Any conviction for a misdemeanor related to the health and safety of a child.
 - b) Any felony conviction.
 - c) Any pending criminal charges.
 - d) The applicant has been convicted of four (4) or more misdemeanors (that are not related to the health and safety of a child).
 - e) The applicant is currently on probation or parole.
 - f) The applicant has been identified as a perpetrator of child abuse or neglect.
 - g) The applicant has a record of substantiated child abuse or neglect
 - h) Provider test positive for any of the drugs tested for in the 5-Panel drug screen described above.
 - i) Provider has been decertified as a provider or breached a contract with any division within FSSA or one of its designees (e.g., Medicaid, DMHA, Division of Aging, Division of Disability and Rehabilitative Services), leading to a termination in contract between the two parties.
 - i) In this case, a provider may reapply as a provider if they meet the following conditions:
 - (1) Provider must wait three (3) years from the date of the decertification or contract termination.
 - (2) Provider must demonstrate that the circumstance(s) leading to the decertification/contract breach have been mitigated satisfactorily.

PROCEDURE FOR PROVIDER RE-CERTIFICATION

| | <i>ACCREDITED AGENCY</i> | <i>NON-ACCREDITED AGENCY</i> | <i>INDIVIDUAL SERVICE PROVIDER</i> |
|---------------------------------------|--|--|---|
| <i>Provider Type Definition</i> | Certified thru DMHA as Community Mental Health Center; or Accredited Community Service Agency | Non-Accredited Community Service Agency | Licensed or unlicensed individual/provider who is not working through another agency. |
| <i>Verification of Qualifications</i> | At least every three (3) years, following their initial certification by | At least every two (2) years, following their initial certification by DMHA. | At least every two (2) years, following their initial certification by DMHA. |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | <i>ACCREDITED AGENCY</i> | <i>NON-ACCREDITED AGENCY</i> | <i>INDIVIDUAL SERVICE PROVIDER</i> |
|--|---|--|------------------------------------|
| | DMHA; or Following their national agency re-accreditation (which ever date is earlier). | | |
| <i>Agency Documentation Requirements</i> | Submit a copy of at least one of the following: DMHA-approved accreditation by a nationally recognized accrediting body: AAAHC, COA, URAC, CARF, ACAC, JCAHO, OR NCQA DMHA certification as a Community Mental Health Center | Submit a copy of the following: Articles of Incorporation | Not Applicable |
| <i>System of Care Affiliation</i> | For providers applying to deliver the Wraparound Facilitation and/or Wraparound Technician services, the following must be met: Letter of support signed by local System of Care which includes both a governing coalition and service delivery system that endorses the values and principles of Wraparound. Or, in the event the area | Not applicable | Not applicable |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | ACCREDITED AGENCY | NON-ACCREDITED AGENCY | INDIVIDUAL SERVICE PROVIDER |
|-------------------------------|---|---|---|
| | of the State does not have an organized System of Care, provider is a part of a DMHA-authorized/designated Access Site for services. | | |
| <i>Required Screenings</i> | <p>Agency must maintain documentation that the individual(s) providing a waiver service has completed the following screens and submitted the results:</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen, or meets the same requirements established for Federal Grant recipients specified under 41 U.S.C. 10 Section 702(a)(1). <p><i>Screenings must be dated within one (1) year of recertification date. See *Note below regarding screenings.</i></p> | <p>Agency must complete and submit a copy of all screening results::</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen, or meets the same requirements established for Federal Grant recipients specified under 41 U.S.C. 10 Section 702(a)(1). <p><i>Screenings must be dated within one (1) year of recertification date. See *Note below regarding screenings.</i></p> | <p>Submit copy of all screening results:</p> <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen. <p><i>Screenings must be dated within one (1) year of recertification date. See *Note below regarding screenings.</i></p> |
| <i>Provider Documentation</i> | Agency must maintain documentation that the individual(s) providing a waiver service meets the | Agency must complete and submit a copy of all screening results:: | <p>Submit proof of the following:</p> <ol style="list-style-type: none"> 1) Current CPR |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | ACCREDITED AGENCY | NON-ACCREDITED AGENCY | INDIVIDUAL SERVICE PROVIDER |
|--------------------------|--|---|--|
| | <p>following standards:</p> <p>1) Current CPR certification</p> <p>2) Maintain on file current documentation at agency demonstrating each individual providing a waiver service(s) meets the service-specific criteria required for each service he/she will be providing.</p> | <p>1) Current CPR certification</p> <p>2) Maintain on file current documentation at agency demonstrating each individual providing a waiver service(s) meets the service-specific criteria required for each service he/she will be providing.</p> | <p>certification</p> <p>2) Current documentation that individual meets the service-specific criteria required for each service he/she will be providing.</p> |
| <i>Provider Training</i> | Agency must maintain documentation of provider's verification /certificates of attendance in at least 30 hours of approved trainings/conferences. | Agency must submit copy of all individuals' verification/certificates of attendance in at least 20 hours of approved trainings/conferences. | Copy of all individuals verification/certificates of attendance in at least 20 hours of approved trainings/conferences. |
| <i>Staff Listing</i> | <p>List of current staff members providing waiver services, including:</p> <p>What service(s) they are providing; and</p> <p>Verification that each staff member has completed all required PRTF Transition Service Provider training or certification.</p> | <p>List of current staff members providing waiver services, including:</p> <p>What service(s) they are providing; and</p> <p>Verification that each staff member has completed all required PRTF Transition Service Provider training or certification.</p> | Verification of completing/attending all required PRTF Transition Service Provider training or certification. |
| <i>Required Forms</i> | Complete, sign (if required) and submit each of the following forms, which can be downloaded and printed from the DMHA website. Visit the following link for more | | |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | ACCREDITED AGENCY | NON-ACCREDITED AGENCY | INDIVIDUAL SERVICE PROVIDER |
|--|---|-----------------------|-----------------------------|
| | information: http://www.in.gov/fssa/dmha/6643.htm . 1) Service Provider Certification Form(s) for <u>each</u> service certification that is being applied. 2) Updated Provider Demographic Form. 3) 3) DMHA Provider Agreement. | | |
| Other Documentation | Each PRTF Transition Waiver Service may have its own service-specific verification that will be required. Submit the additional documentation (if indicated), as defined on each Service Provider Certification Form. | | |
| Submit Provider Application and Documentation to: | PRTF Transition Waiver Provider Specialist Indiana Division of Mental Health and Addiction 402 West Washington Street, Room W353 MS #15 Indianapolis, IN 46204-2739 | | |
| <p>* Screenings Note:</p> <p><u>Drug Screens:</u> Individuals who submit paperwork to become a certified provider under the waiver must complete a 5-Panel Drug Test (THC, Cocaine, Amphetamines/ Methamphetamines, Opiates, and PCP).</p> <ol style="list-style-type: none">1) DMHA will only accept urine screens from agencies or places of business that conduct urine screens. The results must be submitted on the agency or place of business letterhead.2) The Department of Health and Human Services cut-off levels to determine whether the test is positive or negative will be used.3) A 5-Panel drug screen will not be required if the Agency is in compliance with the same requirements established for Federal grant recipients specified under 41 U.S.C 10 Section 702(a)(1).4) All providers that submit a positive drug screen for the above mentioned drugs will be decertified.5) Providers who are decertified will have the right to appeal DMHA's decision. | | | |

INDIVIDUAL SERVICE PROVIDER TRANSFER TO AN EXISTING AGENCY

This Policy outlines the transfer requirements for DMHA approved Individual service providers who wish to begin working for a DMHA-approved agency; or an Individual staff member of a DMHA-approved agency wishing to transfer between DMHA-approved agencies.

- 1) An Individual Provider who wishes to begin working for a DMHA-approved agency, or an individual staff member of an approved agency wishing to transfer between DMHA-approved agencies, must be in *good standing* with DMHA.
 - a) *Good standing* is defined as having no open or pending investigations, incidents or complaints.
 - b) Individuals *not in good standing* are considered to be in *suspended* status and must wait until the open or pending investigation, incident or complaint is closed before transferring. These individuals must be found in *good standing* by DMHA before a transfer is granted.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 2) The Agency accepting the transfer must verify the Individual's *good standing* status with DMHA by submitting an *Agency Transfer Inquiry* form to DMHA no later than sixty (60) days before the proposed transfer date.
- 3) Once *good standing* status is verified, DMHA will need the following from the agency the individual is transferring to:
 - a) A complete provider demographic form from the new agency requesting to "Add Provider to Agency".
 - b) Provider Certification form for the service the individual wishes to provide.
 - c) Supporting documentation to verify the provider is qualified to provide the service.
- 4) Information is sent to the DMHA Provider Relations Specialist.
- 5) DMHA will send a Provider Approval form to the Agency in which the individual is transferring to, in order to verify the change has been approved by DMHA.
- 6) The individual transferring must meet all service provider training requirements, including recertification continuing education units (CEU's).
- 7) An individual transferring must meet requirements based on the schedule below (The training requirement date is based upon the Requested Transfer Date listed on the individual's Transfer Status Form paperwork):
 - a) January - March transfer: No additional CEU's required.
 - b) April - June Transfer: All individuals must have attended at minimum of three (3) hours of approved trainings/conferences.
 - c) July - September Transfer: All individuals must have attended at minimum of eight (8) hours of approved trainings/conferences.
 - d) October - December Transfer: All individuals must have attended at minimum of six (6) hours of approved trainings/conferences.
- 8) An individual will not be transferred until all training requirements have been met.
- 9) Individuals and/or the Agency requesting a transfer may inquire into the reason why an individual is in *suspended* or *non-transferrable* status by signing a *Release of Information* form.
- 10) The Agency requesting a transfer must have written authorization from the individual in question to inquire about the status.
- 11) Failure to follow these guidelines could result in corrective action up to and including decertification of the individual and/or the agency.

LICENSED FOSTER PARENTS AS PROVIDERS

Respite Care may only be provided through the local licensed child-placing agency when provided in a licensed foster home. The licensed child-placing agency must be the DMHA-approved service provider.

SECTION 4: PROVIDER AGREEMENT & EXPECTATIONS

PRTF Transition Waiver providers are enrolled in the Indiana Health Coverage Programs (IHCP) and have executed an *IHCP Provider Agreement* with the Indiana Family and Social Services Administration (IFSSA). This agreement states that the provider will comply, on a continuing basis, with all of the federal and state statutes and regulations pertaining to the IHCP, including the PRTF Transition Waiver program rules and regulations.

IHCP PROVIDER AGREEMENT

By signing the IHCP Provider agreement, the provider agrees to follow the information provided in the *IHCP Provider Manual*, as amended periodically, and the *PRTF Transition Waiver Provider Policy & Procedure Manual*, as well as all provider bulletins and notices.

All amendments to the *IHCP Provider Manual*, *PRTF Transition Waiver Provider Manual*, all applicable Indiana Administrative Codes (IACs), Rules, and Regulations are binding upon receipt or publication. Receipt of all information is presumed when mailed to the provider's current *mail to* address on file with the IFSSA or the Medicaid fiscal agent.

PROVIDER RECORD UPDATES

Provider information is stored in two systems, IndianaAIM and INsite. IndianaAIM is maintained by the Medicaid fiscal agent and INsite is maintained by IFSSA:

- 1) IndianaAIM is the Medicaid Management Information System (MMIS). Maintenance of IndianaAIM requires that the fiscal agent (IHCP) has accurate *pay to*, *mail to*, and *service location* information on file for all providers. It is the provider's responsibility to ensure the information on file with the fiscal agent is correct.
- 2) INsite is the State's system that stores Participant demographic and eligibility information, along with the Participant's cost comparison budget (CCB), which provides the Participant's plan of care (POC) notice of action (NOA) that prior authorizes all waiver services, service providers; and level of care (LOC).
- 3) INsite also contains a provider database that is maintained by the DMHA PRTF Transition Waiver Provider Specialist; and is intended to provide up-to-date information to the field about the certification status of potential PRTF Transition Waiver service providers. Provider selection profiles (Pick Lists) and Bulletin distributions are generated from the INsite data base. Therefore, it is very important that the provider information listed is the most current and up to date information. It is the provider's responsibility to ensure the information on file with DMHA is correct.

Note: To ensure timely communication of all information, providers must notify the IFSSA Medicaid fiscal agent (IHCP) and DMHA PRTF Transition Waiver Provider Specialist when enrollment record information changes.

Due to the importance of accurate information, service providers are responsible to make timely updates of the following information:

- 1) Systems Update Only: The following information changes require a system update with DMHA and IHCP, within ten (10) days of the change:
 - a) Change in telephone number
 - b) Change in Home Office address

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- c) Banking information changes
- 2) **Certification Change Request and System Update:** The following changes will require a certification change request being submitted to DMHA and IHCP:
 - a) Name changes
 - b) Additional service locations
 - c) Tax Identification Number changes
 - d) Changes in Ownership (CHOW)
 - e) Changes in *Mail to, Pay to* and/or *Home Office* information

An IHCP Provider Enrollment staff member works directly and closely with the DMHA PRTF Transition Waiver Provider Specialist to complete and maintain accurate provider enrollment information. However, the responsibility for ensuring information is updated with DMHA and the Medicaid Fiscal Agent falls solely on the provider.

It is the responsibility of the provider to ensure the updates and certification change requests are made in accordance with the following procedures:

SYSTEM UPDATE CHANGE ONLY

These are changes that do NOT require a certification change request:

- 1) Providers are required to submit address and telephone change information to the fiscal agent, IHCP, within ten days of any change.
 - a) Forms are available on the IHCP Web site at <http://www.indianamedicaid.com>, via the Provider Home page Quick Links “*Update Provider Profile Information*”.
 - b) Follow the instructions given.
- 2) Provider information changes must also be submitted in writing to the DMHA PRTF Transition Waiver Specialist at:

PRTF Provider Specialist
Indiana Division of Mental Health and Addiction
402 W Washington St, Room W353 MS #15
Indianapolis, IN 46204-2739

CERTIFICATION CHANGE REQUEST AND SYSTEM UPDATE

Changes that require a certification change must follow these procedures in the order provided below:

- 1) **DMHA Certification Change Request:** Provider is responsible to send notification and request for a change in certification, based upon the changes listed above in *Provider Record Updates* subsection.
 - a) DMHA will review and has the authority to approve or deny the certification change request.
 - b) Once updated certification requirements have been met for the provider, the PRTF Transition Waiver Provider Specialist sends a *waiver service certification letter* to the provider detailing the approved services and instructing the provider to begin the update process with the Medicaid Fiscal Agent at IHCP Provider Enrollment.

Note: All questions regarding the status of the PRTF Transition Waiver IHCP provider's enrollment or updates should be directed to the IHCP Provider Enrollment Customer Service helpline at 1-877-707-5750, not the DMHA.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 2) *IHCP provider enrollment update*: Once approval is obtained, the provider is required to update their provider enrollment information thru IHCP,
 - a) Providers may obtain an IHCP Provider Enrollment Update Form from the (IHCP) Web site at <http://www.indianamedicaid.com> > Providers > Quick Links “Forms” and “Update Provider Profile Information” or by contacting the Provider Enrollment Customer Service helpline at 1-877-707-5750 to request the Update Form.
 - b) Providers must complete the Update Form with appropriate signature, and submit the form along with the PRTF Transition Waiver certification letter, as necessary to the following address:

**Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263**

- c) The IHCP Provider Enrollment analyst will review the Update Form and documents to ensure completeness according to the Provider Enrollment guidelines and update the provider's information in IndianaAIM.
- d) An automated provider letter will be generated and submitted to the provider detailing the changes made to the enrollment record. Providers are encouraged to review this letter to ensure enrollment accuracy.

Miscellaneous Changes

- 1) *Loss of Licensure or accreditation*: DMHA needs to be made aware of this situation immediately. Contact the Provider Relations Specialist.
- 2) *Add Services*: DMHA must authorize any addition of waiver services. Complete and send the following information to the DMHA Provider Relations Specialist:
 - a) Updated Provider Demographic form, including the new information. Circle “Add services”.
 - b) Provider Certification form for the service provider/agency is interested in adding.
 - c) Include supporting documentation to verify the provider is qualified to provide the requested new service.
 - d) The DMHA Provider Relations office will send a Provider approval form to the provider to verify the change has been made with DMHA.
- 3) *Delete a Service from the Pick List Database*: If provider wishes to stop providing a service, notify DMHA in writing so the Pick List database may be updated to reflect the change.
- 4) *Add Additional County or Additional Service Location*: DMHA must authorize any addition of service locations or expansion of counties served for waiver services. Complete and send the following information to the DMHA Provider Relations Specialist:
 - a) Updated Provider Demographic form, including the requested additional service location or county of service for waiver services. Circle “add additional service county”.
 - b) The DMHA Provider Relations office will send a Provider approval form to the provider to verify the change has been made with DMHA.
 - c) If a new office site location is opened, report the change to HP at www.IndianaMedicaid.com.

SOLICITATION POLICY

The purpose of this policy is to clarify the PRTF Transition Waiver rules and regulations regarding solicitation of services.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 1) *State Regulation:* This waiver program adheres to State Regulation regarding solicitation of services. Under Title 405 of the Indiana Administrative Code 5-1-4, solicitation of services, it states the following:

Solicitation, or a fraudulent, misleading, or coercive offer by a provider to provide a service to a Medicaid recipient, is prohibited. Examples of solicitation include, but are not limited to, the following:

- a) *Door-to-door solicitation.*
- b) *The use of any advertisement prohibited by federal or state statute or regulation.*
- c) *Any other type of inducement or solicitation to cause a recipient to receive a service that the recipient either does not want or does not need.*

- 2) *Accepting Referrals and Quid Pro Quo:* Service providers/agencies must not make acceptance of a referral for one service contingent upon Participant receiving another service through the service provider/agency.

For example, it is not acceptable for a provider/agency to accept a referral for Respite Care in return for the Participant also receiving Habilitation services from the same service provider/agency.

Note: *Solicitation, or a fraudulent, misleading, or coercive offer by a provider to provide a service to a Medicaid recipient, is prohibited.*

- 3) *Brochures and Provider Biographies:* An agency or individual provider may develop a brochure or a biography about themselves, their agency, and/or their staff.
 - a) Information in the brochure or biography may include education, hobbies, interests, areas of specialty, etcetera.
 - b) The brochure or biography must only be given to the Access Site of each county in which the agency or individual provider is approved to conduct business.
 - c) If a family member is interested in interviewing the agency/provider, the Access Site will provide the brochure or biography to the family for review.
- 4) *Marketing activities at conferences/tradeshows:* Service providers/agencies may set up informational booths and distribute materials with basic information about the waiver services at conferences, tradeshows or other outreach events with the following restrictions:
 - a) Marketing collateral material may include information about the provider/agency, what services they provide under the waiver, and where they are located.
 - b) Contact at the event must be initiated by the Participant, their family or authorized representative and not the service provider/agency.
- 5) *Websites and Social Media:* DMHA recognizes that social media is becoming the fastest growing way to communicate and distribute information. Service providers/agencies may disclose they provide waiver services on a Facebook page and/or a website and are required to abide by the following restrictions:
 - a) Service provider/agency may not initiate contact with former, current or potential clients for the purpose of securing additional business through the waiver services program.
 - b) Service provider/agency may not solicit new, potential clients through the social media. However, potential clients may contact the provider to request information about the waiver services program through these mediums.
 - c) Service provider/agency may not display any material on a social media platform or website which could be harmful or damaging to the integrity of the waiver services program, or that may reasonably be interpreted as solicitation.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 6) DMHA reserves the right to make the final determination on whether or not a document or marketing activity is deemed as solicitation and in violation of the State regulation.
- 7) Service providers/agencies are strongly encouraged to submit questions regarding marketing activities/collaterals that cite the waiver services program to DMHA for review.
- 8) Failure to follow this policy could result in corrective action up to and including decertification of the provider/agency.

PROFESSIONAL CODE OF CONDUCT AND SERVICE DELIVERY EXPECTATIONS

These guidelines are intended to clarify service delivery standards expected of all DMHA-approved service providers. All services and method of service delivery must honor the family's values and culture; and protect their right to privacy.

- 1) The following are **not** allowable activities with waiver Participants:
 - a) Taking the Participant to provider's private or personal residence for any reason;
 - b) Buying gifts for the Participant;
 - c) Allowing the Participant to participate in provider's family outings;
 - d) Any activity for which the Participant's parent is responsible for and capable of doing;
 - e) Sharing information about the Participant/family with anyone who is not directly involved in the care of the Participant without permission from the parent/guardian.
 - 2) When a service provider is providing services that he/she typically provides to others in the home, such as piano lessons, the guardian or another adult (18 years or older) who has been designated by the guardian must accompany the Participant to the home and be available during the lesson.
 - 3) **Rewards:** Deciding to provide a major reward to a waiver Participant for accomplishments is a Child and Family Team decision.
 - a) The team decides an appropriate reward for a specific accomplishment; and the activity is noted in the Participant's plan of care.
 - b) If the team determines it is appropriate for the provider to participate in the reward, this is also noted in the plan.
 - c) Providers cannot bill their time to the waiver while participating in the reward activity.
 - d) Providers and other participants may be eligible for flex funds to pay for the cost of the reward, but this must be delineated clearly in the plan of care (Refer to *Section 18: Flex Fund Service* for additional information regarding Flex Funds).
- Note:** Any suspected or known misconduct on the part of a waiver service provider or agency must be reported to DMHA on an Incident Report.
- 4) **Family friends who become service providers:** Individuals, who are friends with or provide services to a Participant/family prior to becoming a waiver services provider for the family, must differentiate between the personal relationship with the Participant/family and waiver service provision. Activities engaged in with the Participant prior to becoming a provider may not be eligible for reimbursement under the waiver. When providing waiver services the provider's actions must meet all requirements and standards of the waiver.
 - 5) **Healthy Boundaries:** Below are suggestions to help with awareness and management of boundary concerns for all providers:
 - a) Provider's role in the context of the Participant's care must be clear to both the provider and the family. Make sure expectations are clear at the Child and Family Team meeting.
 - b) Specific activities provided must be outlined on the Notice of Action Supplemental form and must address a need (or encourage a strength) identified by the Child and Family Team.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- c) If the Participant/family asks provider to do something more, less, or differently than the activity identified through the team process, the provider must contact the Wraparound Facilitator.
 - d) Follow all PRTF Transition Waiver service delivery requirements.
 - e) Talk to the Wraparound Facilitator or other mental health professional when uncertain about how to respond to a Participant/family's behavior.
 - f) Address boundary issues as they arise with the Participant/family; emphasize the importance of maintaining objectivity and that rejecting an activity does not imply a lack of caring.
 - g) Do not discuss issues regarding claims and billing with the Participant/family. This increases the family's stress. Request assistance with billing issues from the Wraparound Facilitator or the Medicaid fiscal agent.
- 6) Although it is not uncommon for strong emotional bonds to form, particularly when providing services to children in need, the limits of service provider relationships with Participants/families must be established and maintained to assure mutual respect, a sense of control for both the service provider and the Participant/family, as well as therapeutic rapport.
- 7) Any known or suspected violation of professional conduct or conduct found to be inappropriate or inconsistent with DMHA/OMPP expectations for a waiver service provider must be reported to DMHA through the Wraparound Facilitator on an Incident Report.
- 8) Failure on the part of a service provider/agency to follow these guidelines while identified as a waiver services provider on the plan of care will result in a DMHA corrective action and/or possible decertification of the service provider/agency.

SECTION 5: DOCUMENTATION STANDARDS & GUIDELINES

All service providers must comply with the standards for documentation required for each PRTF Transition Waiver service. The following general documentation standards apply to all waiver services. However, each specific waiver service may have its own unique documentation requirements in addition to the general requirements listed here.

Documentation standards specific to each PRTF Transition Waiver service are detailed, along with the service definitions, scope, limitations and exclusions, in subsequent sections of this manual (Refer to *Sections 13 – 20* of this manual). Providers are responsible for understanding the requirements and limitations for each service they are certified to provide. Questions about a service and its requirements may be directed to the Quality Assurance Specialist assigned to the provider's service area.

Note: Providers are responsible for understanding the service scope and documentation requirements for each service they are certified to provide. Questions about a service may be directed to the Quality Assurance Specialist assigned to the provider's service area.

The format for clinical documentation is up to the individual provider or agency. However, the State expects the provider to understand the following for each waiver service that is billed for reimbursement:

- 1) All documentation is subject to review by the Centers for Medicare and Medicaid Services (CMS) and the State, or its designees.
- 2) Eligibility for claims payment under the waiver program is based on the provider maintaining the required documentation.
- 3) The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.

MAINTENANCE & SUBMISSION OF DOCUMENTATION FILES

All PRTF Transition Waiver documentation must adhere to the *Documentation Content* requirements for the waiver, which are listed below. Additional documentation requirements may exist for each service and can be referenced in the subsequent Service Definition sections of the Manual (Refer to *Manual Sections 13 – 20*).

Providers are required to maintain a Participant file that includes copies of, but not limited to, the following:

- 1) *Plan of Care (POC)*: an individualized treatment plan that integrates all components and aspects of care that are deemed medically necessary/clinically indicated for a waiver Participant. (Refer to *Manual Section 11* for additional information requirements for a Plan of Care).
- 2) *Crisis Plan*: Plan of action developed by the Participant and family in the Child and Family Team, which includes anticipated crisis(es) Participant may experience, interventions and the plan of action for Participant, family and members of the Child and Family Team in the event of a crisis (Refer to *Manual Section 12* for additional information and requirements for the Crisis Plan).

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 3) *Notice of Action (NOA) statements*: Documentation authorizing the PRTF Transition Waiver service(s); units of service; and the authorized provider(s) of the service(s) (Refer to *Manual Section 6* for additional information about service authorization). The NOA must be signed by the Participant's caregiver. It is the responsibility of the Wraparound Facilitator to maintain a copy of the signed NOA in the Participant's clinical file.
- 4) *Service Notes*: the daily contact log or progress note that is completed to document contact between the Participant and provider and provision of a waiver service.
 - a) Service notes must be signed by the provider of the service and maintained in the Participant record.
 - b) All provider service notes are subject to review by the Wraparound Facilitator, who has the responsibility for oversight of the Participant's plan of care/cost comparison budget and provision of services.
 - c) These notes may be submitted to the Wraparound Facilitator monthly, or more frequently, if agreed upon by the Child and Family Team or required by the Wraparound Facilitation Agency.
- 5) *Electronic Record Requirements*: For those providers using an electronic record keeping system, the provider must print, sign and date all case notes and maintain them in the clinical record for the waiver participant.
- 6) *Monthly Report*: All service providers must retain a copy of the monthly report submitted to the Wraparound Facilitator.
- 7) *Child and Family Team Meeting Notes*: Meeting notes documenting the Child and Family Team meetings.
- 8) *Child and Adolescent Needs and Strength Assessment tool (CANS)*: the DMHA-approved assessment tool that is used to assess the Applicant's/Participant's strengths, needs and level of functioning (Refer to *Manual Section 9* for additional information about the CANS assessment tool).
- 9) All other documentation pertaining to the Participant, Family and Child Team meetings, referral, evaluation, reassessment, service delivery and incidents, as required by DMHA and the State.

Standard Content for All Documentation

The following content must be documented in each PRTF Transition Waiver Services service note:

- 1) Participant's name;
- 2) Recipient Identification Number (RID, aka Medicaid Number);
- 3) Waiver service provided (Be specific about type of service provided);
- 4) Total number of service units provided;
- 5) Primary location where service was provided;

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 6) Date and time of the service (these must match date on claim and units billed);
- 7) Provider rendering the service, including, the last name, first initial and credentials (if applicable) of the person providing the service/making the documentation;
- 8) Legible signature of person completing the documentation; and
- 9) Need identified on the CANS that is being met through provision of the service.
- 10) Goal being addressed by service delivered.
- 11) Participant response to service provided;
- 12) Any other specific documentation required for the waiver service provided (Refer to *Manual Sections 13 through 20* for service descriptions and requirements).

Monthly Status Reports

Communication is key to the success of the Wraparound service delivery system. Submission of clinical information is required by all service providers. The *Monthly Status Report*, a brief summary of all service note documentation from the preceding month, is one of the communication methods used by the Wraparound team to summarize the Participant's reaction to services and movement towards achieving the POC goals. The following is required by all service providers:

- 1) To submit a *Monthly Status Report* to the Wraparound Facilitator assigned to the Participant being served, within five (5) business days the following month (Example: Month end is October 31st; Monthly report will be due within 5 business days after that date).
- 2) The monthly report must include the following:
 - a) Summary of the services and support activities provided;
 - b) Participant's progress toward outcomes in the Participant's Plan of Care; and
 - c) Summary of any issues affecting the Participant's health and welfare that require intervention by a healthcare professional or other service provider.
 - d) Total # of units/hours of waiver services provided that month with associated dates of service(s).
- 3) The documentation must adhere to all standards for *Documentation Content*, noted above.
- 4) A copy of the monthly report must be retained in the Participant's clinical record.
- 5) If agreed upon in the Child and Family Team meeting, or a requirement of the Wraparound Facilitator agency, notes and service documentation submission requirements may be more frequent than monthly.

SECTION 6: CLAIMS & BILLING OVERVIEW

The federally approved PRTF Transition Waiver authorizes the Indiana Medicaid program to reimburse eligible providers for the provision of defined home and community-based services. This section summarizes the general claims and billing procedures for PRTF Transition Waiver service providers. Additional billing information and requirements that are specific to the service being billed are provided in service definition sections (*Manual Section 13 through Section 20*).

In order for providers to be reimbursed, all PRTF Transition Waiver services provided to a Participant must be:

- 1) Supported by Participant's level of care and intensity of needs for services as documented on the POC;
- 2) Authorized by DMHA and documented on the Notice of Action (NOA) distributed to the Participant/family and service provider(s);
- 3) Provided by a service provider certified by DMHA to provide the service;
- 4) Provided within the scope, duration and frequency, as defined on the participant's POC and the NOA (*Refer to the Waiver Services Authorization subsection below for additional clarification*); and
- 5) Billed according to Medicaid PRTF Transition Waiver service billing procedures.

Note: *The provision of a Waiver service must be compliant with the service definition, allowed and non-allowed activities and all applicable service limitations. Services provided outside of the CMS approved service definitions and related requirements cannot be billed.*

All service providers are responsible for understanding and following all policy and procedures associated with the provision of and billing for waiver services. Waiver services not meeting the above requirements will be denied for payment.

ELIGIBILITY IMPACT ON BILLING

The following eligibility factors affect the processing of and payment of a PRTF Transition Waiver service claim:

- 1) **Participant Eligibility:** All PRTF Transition Waiver Participants must be enrolled in the IHCP for both the Medicaid program and PRTF Transition Waiver services.
 - a) At this time, waiver Participants may not be enrolled in both the PRTF Transition Waiver program and Hoosier Healthwise, the Medicaid Risk-Based Managed Care Organization. Therefore, potential PRTF Transition Waiver Participants must be de-enrolled from Hoosier Healthwise before they can be eligible for PRT Transition Waiver services.
 - b) Participant must have an open PRTF Transition Waiver level of care status in IndianaAIM for the dates of service being billed.
 - c) Participant's Medicaid eligibility must be current. The Wraparound Facilitator is responsible to verify and notify service team regarding the IHCP eligibility for each Participant prior to the provision of waiver services, as explained in the IHCP Provider Manual and on the www.indianamedicaid.com web site.
- 2) **Service Provider Eligibility:** All service providers submitting a claim must be:
 - a) Enrolled in Medicaid with an IHCP provider number.
 - b) Certified as an approved PRTF Transition Waiver service provider.
 - c) Documented on the NOA as the authorized provider of service.

- 3) Waiver Service Eligibility: The service being billed must be an eligible waiver service for the Participant. The following must be met in order for reimbursement for a service to be made:
 - a) Service is authorized by DMHA, who makes the final decision regarding the Participant's program eligibility and approves the waiver program start date.
 - b) The approved PRTF Transition Waiver level of care, authorized service(s), including the service frequency and start date is entered into IndianaAIM, which allows reimbursement of authorized waiver services provided on or after the waiver service's authorized start date. Additional information about service authorization is detailed below in the Service Authorization Section.

WAIVER SERVICES AUTHORIZATION

The Notice of Action (NOA) is an integral part of the authorization process for PRTF Transition Waiver services. This written notice is generated and provided to the Wraparound Facilitator (who provides it to the Participant, family and service providers on the POC) when DMHA approves waiver services on a submitted Plan of Care (POC) and the Cost Comparison Budget (CCB). The NOA documents any action or decision that would affect the Participant's eligibility and benefits for PRTF Transition Waiver services, and includes the following information:

- 1) Actions to approve or deny an Applicant's eligibility for waiver services
- 2) All authorized waiver services DMHA-approved for the Participant, including:
 - a) Service type;
 - b) Number of units to be provided;
 - c) Name of the authorized provider(s) of the service; and
 - d) Approved billing code with the appropriate modifier for the service.
- 3) Subsequent changes to increase, reduce or terminate, any or all waiver services;
- 4) The effective dates and reasons for the action(s) taken; and
- 5) The Participant's appeal and fair hearing rights and procedural information.

Note: Providers must not render or bill services without a DMHA-approved NOA.

The NOA is a result of the Wraparound Facilitator entering updated POC/CCB information in the INsite system and DMHA reviewing and making an approved or denied determination. The Wraparound Facilitator is responsible for ensuring the Participant/family receive the NOA information.

INsite communicates this data to IndianaAIM, where it is stored in the Prior Authorization database; and is used during claims processing.

The following represents ***common reasons for a claim to be denied for waiver services***:

- 1) Service billed for is not an approved service on the NOA;
- 2) Service provider is not authorized on NOA to provide the billed service;
- 3) Date of service being billed does not match dates authorized;
- 4) Units of service billed exceed the authorized amount; or
- 5) Code/modifier on claim is something other than the approved code/modifier on the NOA.

It is each service provider's responsibility to:

- 1) Understand the service scope and limitations for each PRTF Transition Waiver service they are authorized to provide for the Participant, as documented on the Notice of Action (NOA);

- 2) Notify the Wraparound Facilitator assigned to the Participant, if a service provided is not in agreement with the service authorized on the NOA; or
- 3) The Participant's intensity of need for services is no longer consistent with the approved services documented on the NOA.

BILLING INSTRUCTIONS

When completing the billing process, the provider must use the service procedure code, modifier, unit of service and service rate associated with an approved service on the NOA.

All PRTF Transition Waiver claims are billed through Medicaid by one of the following means:

- 1) CMS-1500 claim form; or
- 2) Via the 837P electronic transaction.

Refer to Manual Sections 13 through 20 for the individual waiver service definitions, billing codes (HCPCS Codes and Modifiers), service rates and units of service information. It is the provider's responsibility to seek out the most up-to-date billing information regarding Medicaid's procedures for claims and billing. Medicaid billing information, Provider Bulletins, claims forms and instructions are available to the provider on Medicaid's www.indianamedicaid.com website. For information about billing waiver services, also refer to information provided at: <http://provider.indianamedicaid.com/general-provider-services/manuals.aspx> (Refer to Chapter 8, Section 6 Home and Community-Based Services Waiver Billing Guidelines for general claims filing information; and Table 8.160 on the CMS-1500 claim form fields.)

The IHCP encourages all waiver providers that have an NPI and LPI to bill using only the LPI for waiver services. Waiver providers that choose to bill with an NPI associated with multiple LPIs must ensure that a taxonomy code is not indicated on the claim. If the taxonomy code is included on a waiver claim, payment may be made to the wrong service provider.

Example if provider does bill with the NPI: *An entity performs waiver and Medicaid home health services. Both entities use the same NPI for billing and have the same ZIP code. When submitting claims, the home health provider must bill using the NPI and a taxonomy code. The waiver provider must bill using the NPI without the taxonomy code. If the waiver claim is billed with the NPI and taxonomy code, payment is sent to home health providers.*

Note: Waiver providers are encouraged to bill using their LPI to ensure more accurate payment.

BILLING UNITS OF SERVICE

Refer to *Manual Sections 13 through 20* for the Units of Service information for any PRTF Transition Waiver service being billed. The information below is general information regarding Medicaid's expectations on billing units of service.

- 1) *Billing 15-minute units of service* for a waiver service provided on a date of service:
 - a) In order to bill one 15-minute unit of service, a minimum of 8 minutes must be provided.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- b) Units of service activity time for one day are totaled to submit one claim.
- a) Remaining units that are less than 8 minutes may not be billed or added to partial units on other days of service.
- 2) *Round partial units of service for single visit on date of service as follows:*
 - b) A partial unit of service totaling eight (8) minutes or more is rounded up to a 15-minute unit of service.
 - c) A partial unit of service totaling seven (7) minutes or less must not be rounded up and cannot be billed or added to partial units on other days of service.
- 3) *Round partial units of service for multiple visits on same date of service as follows:*
 - a) *Activities requiring seven (7) minutes or less* may be accrued to the end of that date of service. In this situation, the guidelines above regarding rounding of any remaining partial minutes will apply.
 - b) Multiple visits on the same date of service must be billed on the same claim form and on one detail with the total number of units of service provided.
 - c) Billing on separate lines for the same date of service causes claims to be denied as exact duplicates.
- 4) *Billing daily units of service (e.g., Respite service)*
 - a) Daily units of service may be billed daily, or totaled weekly, or monthly.
 - b) Respite – Routine Daily: one (1) unit of service provided is 7 to 24 hours on a date of service.
 - c) Respite – Crisis Daily: one (1) unit of service provided is 8 to 24 hours on a date of service.
 - d) Respite – in PRTF: one (1) unit of service for the date of service is established by the current Medicaid-certified PRTF billing policy in effect at the time of the service. The current policy is based on the individual census taken at midnight on the date of service.

Note: Respite service being provided to two (2) or more Participants in the same home, at the same time by the same provider, must total units of service for that date of service and Provider must divide the units accordingly. The Respite service for each Participant is billed separately. Billing total hours to each Participant is considered *duplicate billing* and is not allowed. (Doing so may constitute fraud.)

BILLING SERVICES THAT DO NOT HAVE A DEFINED BILLING RATE

Not all PRTF Transition Waiver services will have a defined billing rate and authorized items and services vary widely, according to the approved service(s) for the Participant. The two waiver services without an established billing rate include:

- 1) Flex Funds Service
- 2) Non-Hourly Training and Support for Unpaid Caregivers Service

Authorized items and services vary widely, based upon the approved POC/CCB and the NOA. These items are bound by the service-specific scope and limitations (Refer to *Manual Section 18 and Section 20* for limitations associated with Flex Funds and Non-Hourly Training and Support services). The following general information applies to Flex Fund and Non-Hourly Training and Support for Unpaid Caregivers services:

- 1) Services are billed in \$1.00 *units of service*. Cents of \$.50 or more are rounded up to \$1.00 and down for \$.49 cents or less.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- a) *Single Item Example:* \$20.00 for a given item of service (i.e., a music book for piano lessons) is billed as twenty (20) \$1.00 *units of service*.
- b) *Multiple Items Example:* If multiple services provided on the same date of service *(i.e., Flex Funds: \$25.00 for art supplies and \$50.00 membership at YMCA) are totaled and billed as the totaled units of service. In our example the art supplies and membership would be billed at seventy five (75) \$1.00 *units of service*.
- 2) The Wraparound Facilitator is responsible for maintaining documentation to support claims for all items and services purchased through the Flex Fund and Non-Hourly Training and Support for Unpaid Caregivers services.
- 3) The Wraparound Facilitator must have documented authorization for the specific item(s)/service(s) purchased and maintain receipts to document the item(s) billed by *date of service*. Additional required information includes:
 - a) Item(s) purchased;
 - b) Cost(s) of item; and
 - c) Where the item was purchased or service was provided.
- 4) Families are to be instructed to keep purchase receipts for items purchased by waiver funds separate from non-waiver funded items purchased.

Example: The family purchased authorized art supplies for the Participant, as well as school supplies for another non-Participant member of the family. The family should have a separate receipt for the items funded solely by the waiver.
- 5) If there are multiple Participants in the same household, the family must be able to provide separate expenditure receipts for each individual Participant. Federal regulations do not allow for mixing of funds between two or more Participants.
- 6) Failure to provide separate receipt documentation for waiver/non-waiver or for each individual Participant for which expense(s) was authorized will result in denial of the entire expenditure.

CLAIM TIPS & REMINDERS

When billing Medicaid PRTF Transition Waiver claims, provider must consider the following:

- 1) The IHCP does not reimburse time spent by office staff billing claims.
- 2) Provider may bill only for those services and units authorized on an approved NOA and for which the provider is designated as the authorized provider.
- 3) A claim may include dates of service within the same month. Do not submit a claim with dates that span across more than one month on the same claim.
- 4) The *units of service* as billed to the IHCP must be substantiated by documentation in accordance with the appropriate Indiana Administrative Code (IAC) regulations and the waiver documentation standards from the CMS-approved waiver application.
- 5) Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned waiver application, rules and standards.
- 6) Updated information is disseminated through IHCP provider bulletins, (mailed to providers and posted on the IHCP Web site) and DMHA bulletins (sent through e-mail and posted on the state

Note: The *units of service* as billed to Medicaid under the Waiver program must be substantiated by documentation that meets Medicaid and Waiver standards and regulations.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

agency Web site). Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Refer to the *IHCP Provider Manual* for instructions on how to complete the paper CMS-1500 claim form. In addition, the Medicaid fiscal agent and the OMPP and DMHA recommend submitting claims electronically. Providers may submit claims electronically using Web interChange. For information about Web interChange, please refer to the IHCP Web site at www.indianamedicaid.com or contact Provider Assistance. The following numbers are a resource for providers needing assistance with Medicaid:

- 1) Provider Enrollment Customer Service (877) 707-5750.
- 2) Claims Customer Service (800) 577-1278.
- 3) Web interchange (enrolling issues or technical support) (877) 877-5182.

CLAIM VOIDS & REPLACEMENTS

If a paid or denied claim must be adjusted (replaced), the initial claim is voided and a new claim takes the place of the old claim.

If the claim was paid before the adjustment was made, any money paid is recouped by setting up an accounts receivable (AR) for the amount of the recoupment, which is identified on the remittance advice (RA).

The CMS-1500 Adjustment form is available on the IHCP Web site at: www.indianamedicaid.com . Instructions for completing the form are located on the website and in the *IHCP Provider Manual* (also available on the IHCP website).

SECTION 7: PROVIDER SUPPORT

PRTF Transition Waiver service providers have access to several resources to assist and support them in their activities with waiver Participants.

QUALITY IMPROVEMENT SPECIALISTS SUPPORT

DMHA contracts with Quality Improvement Specialists (QIS) to engage in the following activities meant to ensure quality program outcomes and support to service providers and Participants/families:

- 1) Responsible for provider training and support to Wraparound Facilitations, service providers and Access Sites.
- 2) Conduct quality reviews to assure program is adhering to federal and state statutes associated with the PRTF Transition Waiver.
- 3) Responsible for review and approval of each Participant's Plan of Care.
- 4) Provide coaching and education for DMHA-approved Access Sites.
- 5) Community Liaison for the waiver services program.

Each QIS is assigned a geographical territory to provide oversight and support. The local QIS will be the point of contact for service providers/Access Sites who have PRTF Transition Waiver questions and concerns.

WEBSITE

DMHA maintains a website intended to educate and assist the public, service providers, Access Sites and Participants/families about the waiver services program and other resources available to the community through DMHA. It also serves as a resource for providers regarding training opportunities, policy and procedures, program updates and public announcements about new and revised programs. Visit the following link for more information: <http://www.in.gov/fssa/dmha/6643.htm>.

It is the service provider's responsibility to check the website on a regular basis for information, updates and announcements that might affect their waiver service activities.

MEDICAID PROVIDER SUPPORT

Medicaid offers resources, education and updates regarding Medicaid service delivery and billing on its website. Providers are responsible for any Medicaid policy or procedure change that would impact how they provide or bill waiver services. For more information, visit the Medicaid Provider website at: <http://www.indianamedicaid.com/>.

SECTION 8: UTILIZATION REVIEW AND QUALITY MANAGEMENT

Indiana's quality management process for the PRTF Transition Waiver includes monitoring, discovery and remediation processes to ensure the following:

- 1) Waiver is operated in accordance with federal and state requirements;
- 2) Participant health and welfare;
- 3) Participant needs goals and preferences are part of the person-centered planning process and reflected in the Plan of Care (POC); and
- 4) Identification of opportunities for ongoing quality improvement.

The quality management and improvement processes are implemented in the following ways:

- 1) Surveillance Utilization Review and Provider Audits.
- 2) Level of Care and Plan of Care Reviews.
- 3) Qualified Provider Enrollment Function.
- 4) Quality Assurance and Improvement Activities.
- 5) Financial Integrity Audits.
- 6) Quality Improvement Strategy.

SURVEILLANCE UTILIZATION REVIEW & PROVIDER AUDITS

The waiver auditing function is incorporated into the Surveillance Utilization Review (SUR) functions of the contract between the Medicaid agency and SUR Contractor. OMPP has expanded its program integrity activities by using a multi-pronged approach to SUR activity that includes provider self-audit, contractor desk audit and full on-site audit functions. The SUR Contractor sifts and analyzes claims data and identifies providers/claims that indicate aberrant billing patterns and/or other risk factors; such as the correcting of claims.

The OMPP or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DMHA may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement.

The following Program Integrity and SUR activities describe post-payment financial audits to ensure the integrity of Medicaid payments:

(Detailed information on SUR policy and procedures is available in the Indiana Medicaid Health Coverage Programs Provider Manual Chapter 13: Utilization Review at <http://provider.indianamedicaid.com/ihcp/manuals/chapter13.pdf>).

The State of Indiana employs a hybrid Program Integrity (PI) approach to oversight of the waiver programs, incorporating oversight and coordination by a dedicated waiver specialist position within the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) Contractor arrangements. The Office of Medicaid Policy and Planning (OMPP) has expanded its PI activities using a multi-faceted approach to SUR activity that includes provider self-audits, desk audits and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and/or referrals, audits are completed as needed. The FADS team analyzes claims data allowing them to identify providers and/or claims that indicate aberrant billing patterns and/or other risk factors.

The PI audit process utilizes data mining, research, identification of outliers, problematic billing patterns, aberrant providers and issues that are referred by other divisions and State agencies. In 2011, the State of Indiana formed a Benefit Integrity Team comprised of key stakeholders that meets bi-weekly to review and approve audit plans, provider communications and make policy/system recommendations to affected program areas. The SUR Unit also meets with all waiver divisions on at a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and aid in understanding specific areas of concern such as policy clarification.

The SUR Waiver Specialist is a Subject Matter Expert (SME) responsible for directly coordinating with the waiver divisions. This specialist also analyzes data to identify potential areas of program risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in review of waiver providers and programs.

Throughout the entire PI process oversight is maintained by OMPP. While the FADS Contractor may be incorporated in the audit process, no audit is performed without the authorization of OMPP. OMPP's oversight of the contractor's aggregate data will be used to identify common problems to be audited, determine benchmarks and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with Federal and State guidelines, including all Indiana Health Coverage Programs (IHCP) and waiver requirements.

LEVEL OF CARE RE-EVALUATION & REVIEW OF PARTICIPANT SERVICE PLANS

DMHA contractors review and approve the Level of Care evaluation and any changes to the Plan of Care (POC). The POC, based upon assessed level of care and Participant/family strengths and needs is effective for up to one year from the initial approval date. Since the Wraparound process is a fluid process, the POC is updated as the Participant's needs for service intensity and response to treatment dictates. It is the responsibility of the Child and Family Team to continually review, assess and address the ever changing needs of the Participant/family through the POC. The Level of Care evaluation is required at least annually and is done using a CANS assessment conducted by the Wraparound Facilitator and approved by a DMHA contractor.

DMHA contractors review the individual POC against documented services rendered to ensure compliance with waiver requirements. Annual redeterminations are reviewed at 100 percent. A designated percentage of Annual Levels of Care are reviewed by the contracted entities as well for accuracy.

Qualified Provider Enrollment: The OMPP has a fiscal agent under contract which is obligated to assist the OMPP in processing approved Medicaid Provider Agreements to enroll approved eligible providers in the Medicaid Management Information System for claims processing. This includes the enrollment of DMHA approved PRTF Transition Waiver service providers. The fiscal agent also conducts provider training and provides technical assistance concerning claims processing. The Medicaid Fiscal Agent contract defines the roles and responsibilities of the Medicaid fiscal contractor.

Quality Assurance & Improvement Activities: The DMHA has contracted with individuals responsible for conducting quality assurance and improvement activities. These contractors work closely with DMHA staff, Medicaid, providers and the local community to affirm all Participants are receiving services based on Waiver policies, procedures, Wraparound Principles and System of Care philosophy. Quality improvement and review activities include:

- 1) Quality improvement reviews of Wraparound Facilitators and various service providers;
- 2) Observation of Child and Family team meetings;
- 3) Communication with families and Participants regarding their treatment and satisfaction with services; and
- 4) Review of Participants' plans of care, crisis plans and any other waiver services documentation, to ensure that services are adequately documented and the plan reflects Participant needs, goals and preferences.

Medicaid Fraud Control Unit Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General's Office. MFCU conducts investigations in the following areas:

- 1) *Medicaid provider fraud;*
- 2) *Misuse of Medicaid members' funds; and*
- 3) *Patient abuse or neglect in Medicaid facilities.*

When the MFCU identifies a provider who has violated one of these areas, the provider's case is presented to the state or federal prosecutors for appropriate action. Access information about MFCU at:

<http://www.in.gov/attorneygeneral/2453.htm>.

Contractors' activities and observations are documented on quality assurance review forms, including any need for corrective action and follow-up requirements for the entity being reviewed. The outcomes of their reviews are included in the waiver program's performance measures used to evaluate program compliance and effectiveness for the Participants and families being served.

FINANCIAL INTEGRITY AUDITS

Providers in accordance with their service agreement must maintain for the purposes of the service agreement an accounting system of procedures and practices that conforms to Generally Accepted Accounting Principles (GAAP).

The OMPP or any other legally authorized governmental entity (or their agents) may at any time during the term of the service agreement and in accordance with Indiana Administrative Regulation conduct audits for the purposes of assuring the appropriate administration and expenditure of the monies provided to the provider through this service agreement. Additionally, DMHA may at any time conduct audits for the purpose of assuring appropriate administration and delivery of services under the service agreement.

The following is the link to the Indiana Health Coverage Programs (IHCP) Provider Manual. Chapter 13 covers Utilization Review: <http://provider.indianamedicaid.com/general-provider-services/manuals.aspx>.

Under the provisions of the Single Audit Act, as amended by the Single Audit Act Amendments of 1996, the State of Indiana utilizes the Indiana State Board of Accounts (SBOA) to conduct the independent audit of state agencies, including the Office of Medicaid Policy and Planning. OMPP routinely monitors audit resolution and provides annual status updates to SBOA.

QUALITY IMPROVEMENT STRATEGY

Information regarding quality is channeled into the DMHA PRTF Transition Waiver Team through the Quality Improvement Strategy (QIS) discovery activities. The sources of information; as well as the methods of collection, aggregation, and analysis are varied. Sources include: waiver participants; families; providers; wraparound facilitators; the public; the Children's Mental Health Advisory Board (which combines the previous CA-PRTF Quality Improvement (QI) Committee and CA-PRTF Advisory Board); DMHA and OMPP staff; the Medicaid Fiscal Agent; Medicaid Management Information System; Surveillance Utilization Review; the INsite database; advocates; other state agencies; and other state and elected officials.

DMHA, the operating agency, and OMPP, the Medicaid Agency, have designed the QIS to obtain the most relevant and accurate information in the most efficient manner possible to establish baseline performance, trends, and priorities.

The PRTF Transition Waiver Team is constantly reassessing its quality strategies and reviewing progress through the discovery strategies outlined in the QIS. The PRTF Waiver Team reviews, compares and analyzes new data; and provides status reports at least quarterly to the Children's Mental Health Advisory Board. Information and commentary is shared with the Board regarding:

- 1) Implemented strategies, including measurable improvement in specific areas (or lack of improvement);
- 2) Difference in results in different areas of the state;
- 3) Length of time that is necessary to achieve system improvement in these areas;
- 4) Unforeseen events;
- 5) Reassessment of an intervention; and
- 6) Termination or permanent adoption of an intervention as part of operations.

Two-way communication with all stakeholders is key, occurs at any time, and takes any form necessary: phone call, listserv, e-mail, formal bulletin, meeting, conference call, flyer, website, or any combination.

To facilitate communications with all stakeholders, DMHA has developed a public website. Visit the following link for more information: <http://www.in.gov/fssa/dmha/6643.htm>.

Through the on-going analysis of data generated including, input from Participants/families, access points, providers and other stakeholders, DMHA continuously evaluates the effectiveness and relevance of the Quality Improvement Strategy.

DMHA evaluates the performance measures outlined in the strategy, the responsible party, the frequency, and sampling approach as information is gathered from incident reports, site visits, provider enrollment reports, INsite reports, complaints, fair hearings and fiscal reports. Changes to the strategy are the responsibility of DMHA with input from OMPP and the Children's Mental Health Advisory Board.

SECTION 9: PARTICIPANT ELIGIBILITY

The intent of the PRTF Transition Waiver is to continue availability and access to intensive, community-based Wraparound services for youth enrolled in the CA-PRTF Demonstration Grant at the time the Grant expired, effective October 1, 2012.

TARGET GROUP

In compliance with the State and Federal regulations associated with the PRTF Transition Waiver, no new Participants will be enrolled into waiver services after October 1, 2012. The Target group for this waiver includes only those youth who were eligible and enrolled in the CA-PRTF Demonstration Grant as of September 30, 2012.

SERVICE AUTHORIZATION

The Participant is not eligible to receive a waiver service unless the service is prior authorized by DMHA and documented on a Notice of Action (NOA). And, service authorization is based upon the Participant's documented level of care, needs for services and plan of care.

Service providers must ensure all Participants meet service eligibility requirements prior to the provision of waiver services, including:

- 1) Current and accurate documentation of a Level of Care is entered in the IndianaAIM system.
- 2) Services provided are compliant with the DMHA-authorized NOA. (Refer to *Billing and Claims* in *Manual Section 6* for additional information about the NOA).
 - a) If any service authorized on the NOA needs to be changed due to a change in the Participant's level of care, the provider is not authorized to make the change without an updated NOA.
 - b) The provider must notify the Wraparound Facilitator of the need and rationale for a possible change in level of care or service delivery.
 - c) It is the responsibility of the Wraparound Facilitator and the Child and Family Team to determine the need for changes to the Participant's plan of care.
 - d) When indicated, changes in service delivery must be documented on an updated plan of care and submitted to DMHA for review and approval prior to a change in service delivery.
 - e) If the updated plan of care is approved by DMHA, a revised NOA will be issued with the updated service(s) and related information.

Note: Participants are eligible for only those waiver services that have been prior authorized by DMHA and documented on the NOA.

CONTINUED ELIGIBILITY FOR WAIVER SERVICES

While initial eligibility for service delivery under PRTF Transition Waiver includes the requirement that the Participant be enrolled in the CA-PRTF Demonstration Grant on the date it expired; continued eligibility requires that the Participant meet the same criteria used to determine eligibility for the CA-PRTF Grant, which includes the following:

- 1) Meet eligibility requirements for a serious emotional disturbances (SED) for children ages 6 through 17 years of age; or meet eligibility criteria for serious mental illness (MI) for youth ages 18 through 20 years of age;

- 2) Eligible for a qualified Medicaid category; and
- 3) Demonstrates a high need for intense services traditionally provided in a PRTF or SOF level of care, as determined by a Behavioral Recommendation from administration of the Child and Adolescent Needs and Strengths assessment tool (Refer to *CANS Assessment and Level of Care* subsection below for additional information regarding the required/allowed behavioral recommendation for waiver service program eligibility).

As defined in the Medicaid-approved PRTF Transition Waiver it is the responsibility of the service provider to ensure that they are providing waiver services to Participants meeting eligibility criteria for this waiver.

The Wraparound Facilitator and the Child and Family Team regularly monitor and evaluate the Participant's progress in treatment and eligibility for waiver services in the following ways:

Note: *The Child and Family Team is responsible to regularly monitor the Participant's level of care and continued eligibility for waiver services.*

- 1) *CFT Meetings*- Monthly, or more frequently scheduled, team meetings provide the entire Child and Family Team an opportunity to evaluate the Participant's progress in meeting treatment goals and response to treatment.
- 2) *Monthly Reports*- The monthly report is used by service providers to summarize the Participant's service utilization, status and progress in the waiver service program.
- 3) *POC Updates*- the Plan of Care is continuously reviewed adjusted as needed to meet the Participant's needs and reflect their strengths. The document is revised by the Child and Family Team any time there is a change in need or service delivery. Note: DMHA must approve any changes to the plan of care prior to services being changed.
- 4) *CANS Assessment*- Administration of the Child and Adolescent Needs and Strengths (CANS) assessment tool is required, every six (6) months, for all Participants. The assessment tool is used to evaluate and determine the Participant's level of care.

When a Participant experiences a change in level of care or a change in eligibility (one in which the participant no longer qualifies for waiver services), the Wraparound Facilitator and Child and Family Team will begin preparing the Participant for a transition from waiver services to more appropriate State Plan services that meet the Participant's current needs and strengths. See *Transitioning Participant from Waiver Services* and *Participant Interrupt, Termination and Re-Start Status Policy* subsections below for additional information.

CANS ASSESSMENT & LEVEL OF CARE

According to the eligibility criteria established in the PRTF Transition Waiver, the Participant must have a high need for intense services traditionally provided in a PRTF or SOF. This level of care is identified from the ratings derived from the administration of the Child and Adolescent Needs and Strengths assessment tool, which is used to assess the Participant and caregiver's needs and strengths.

- 1) The Wraparound Facilitator is the service provider authorized by DMHA to administer the CANS assessment, following the DMHA mandated training and certification program.

- 2) Patterns of CANS ratings (i.e., behavioral health needs, functioning, safety/risks, caretaker needs and strengths) have been used to develop a Behavioral Health Decision Model (algorithm). This algorithm (referred to as a behavioral recommendation) implements the criteria for the level of care and is used to indicate the appropriate intensity of behavioral health services required to address the Participant's identified needs.

The following behavioral recommendations are used to determine a Participant's status in the PRTF Transition Waiver services program:

- 1) A CANS behavioral recommendation of five (5) or six (6), which indicates a need for a PRTF or SOF level of care, meets level of care criteria for continued access to waiver services.

Note: A CANS rating of a 5 or 6 is required for a Participant to be eligible to receive waiver services.

- 2) A CANS rating of a four (4) or lower indicates a change in waiver eligibility and level of care. The Participant no longer meets the level of care required to be enrolled in waiver services and subsequently is to be prepared for transition out of waiver services into a level of care appropriate for the Participant's current level of functioning (see *Participant Transition* subsection below for information). The transition must be completed within ninety (90) days of the CANS assessment administration indicating the change in eligibility.

LOC REVIEW & EVALUATION

A face-to-face evaluation and Level of Care (LOC) review will be conducted with the Participant/family at least every twelve (12) months by a qualified service provider (or sooner if there is a significant change in the Participant's need for services); and will include, but is not limited to, the following:

- 1) Administration of the Child and Adolescent Needs and Strengths (CANS) behavioral assessment tool to determine the Participant's need for services.
- 2) Assessment of Participant's progress towards meeting established treatment goals on the POC.
- 3) Evaluation of current Participant strengths and functional impairments.
- 4) Documentation that Participant still meets Financial, Eligibility and LOC criteria for waiver services; and
- 5) Update the POC/CCB and Crisis Plan or Prepare to transition the Participant from waiver services, dependent upon the results of the LOC review and evaluation.

The evaluation documentation and level of care review results, updated POC and Crisis Plan (if applicable) must be submitted to DMHA for review thirty (30) days prior to expiration of current LOC. Documentation is reviewed by DMHA to determine if the Participant meets eligibility for continued use of waiver services.

- 1) If the core criteria are met, the Participant will be notified by the Wraparound Facilitator and will continue to receive waiver services for up to another twelve (12) months, or until Participant no longer meets eligibility criteria (which ever date is earlier).
- 2) If the waiver eligibility criteria are not met, the following will occur:
 - a) DMHA, or contracted entity, will inform the Participant/family and the service provider(s), via the Wraparound Facilitator, that continued enrollment in waiver services is denied.

- b) The service provider and Child and Family Team will work together with the Participant and family to develop and implement a transition plan to assist the Participant in transitioning from waiver services to community-based services appropriate for the Participant's level of care (*Refer to Transition for Waiver Services policy below in this section*).
- c) The participant/family has the right to appeal the DMHA determination and will be provided with information regarding the Fair Hearing and Appeal process on the Notice of Action.

When a change in eligibility for waiver services does occur, a Data Entry Worksheet (DEW) must be completed by the Wraparound Facilitator and entered into INsite. Refer to *Participant Interrupt, Termination and Re-Start Status Policy* below for additional information.

PARTICIPANT TERMINATION, INTERRUPT, RE-START AND RE-ENTRY STATUS

Participants, due to various reasons may experience an interruption or termination in waiver services, including but not limited to the following examples:

- 1) Participant achieves treatment goals on plan of care, resulting in a change in level of care that does not meet continued eligibility requirements for waiver services.
- 2) Participant will be out of his/her home/place of residence for more than twenty-four (24) hours (e.g., admission to an acute facility, family vacation, etc.).
- 3) Participant reaches 21st birthday, resulting in “aging out” of the waiver services program.
- 4) Participant loses Medicaid eligibility (see subsection below regarding Medicaid eligibility and impact on waiver services).

Note: A DEW form must be submitted to DMHA if the Participant will be out of his/her home placement for longer than 24 hours.

A *Data Entry Worksheet* (DEW) is used to track a participant's movement in and out of the PRTF Transition Waiver services due to a change in eligibility or level of care. The Wraparound Facilitator is required to complete and submit a DEW to the Division of Mental Health and Addiction (DMHA) in the following situations:

- 1) *Interrupt status*- Occurs when a Participant's eligibility status and ability to participate in PRTF Transition Waiver services is temporarily affected by an increase in level of care or other factors that interrupt service delivery (e.g., youth needs higher level of care and is admitted to a more restrictive setting, such as an acute hospital setting or Participant is away from home for reasons other than treatment).
 - a) The DEW must reflect a move to *interrupt* status. This assumes that the eligibility issue will be resolved within 30 days and that once eligibility is re-established, the child will be able to resume an active role in PRTF Transition Waiver services.
 - b) Once eligibility issues are resolved, a *Re-start* DEW is completed to move the participant back to *Active status*.
- 2) *Termination status*- This status is indicated if the eligibility issue is likely to be permanent, or will not be resolved within 30 days (e.g., Participant requires treatment in a psychiatric rehabilitation

treatment or other long-term treatment or correctional facility). The DEW must reflect a Participant's move to *Termination status*.

- a) If an *Interrupt* status reaches 30 days without indication that the status will change and move to *Active*, the participant is placed in *Termination status*.
- b) When a *Termination* DEW is completed, the system automatically creates a Cost Comparison Budget/Plan of Care (CCB) that zeroes out the services in the months after the effective date of the termination. This CCB is auto-approved when imported at the State, creating the Notice of Action (NOA) with the Appeal language.
- c) *Termination* DEW's are reviewed by the Office of Medicaid Policy and Planning (OMPP) staff to ensure that IndianaAIM is appropriately updated.

Note: If Participant does not request a Re-Entry status within the same federal fiscal year as the date of the termination status, he/she will be ineligible to re-enter PRTF Transition Waiver services in subsequent years.

- 3) *Re-start status*- This status is used following an *Interrupt* status of 30 days or less. A *Re-start* CCB is required before services may begin; but no updated LOC review unless the Participant is due for an annual reassessment.
- 4) *Re-Entry status*- Used following a terminated case after more than 30 days.
 - a) If a case is terminated, the PRTF Transition Waiver slot remains available to that child for the balance of the federal fiscal year (October 1 through September 30) in which the termination was completed.
 - b) If Participant wants to resume PRTF Transition Waiver services within the same federal fiscal year as the date of termination (October 1 through September 30), a *re-entry* CCB must be completed and submitted along with a LOC application and Child and Adolescent Needs and Strengths assessment (CANS).
 - c) If the *re-entry* CCB is approved by DMHA, the Participant can resume Transition Waiver services.
- 5) If participant does not request a *Re-Entry* status within the same federal fiscal year as the date of the *termination* status, the Participant will be ineligible to re-enter PRTF Transition Waiver services in subsequent years.
- 6) The following reason codes are used to document the cause of a Participant's change of status (the appropriate code must be documented on the DEW):
 - a) 01 Aged out of program
 - b) 02 Transfer to PRTF
 - c) 03 Transfer to inpatient facility—Non-PRTF
 - d) 04 Increase in functioning—Transition Waiver services no longer needed
 - e) 05 Not eligible for Medicaid
 - f) 06 Incarcerated/Juvenile justice involvement
 - g) 07 Non-Compliant
 - h) 08 Moved/Moved out of state
 - i) 09 Parent chooses to opt out of Transition Waiver Services
 - j) 10 Other: Explain in Comments

PARTICIPANT TRANSITION FROM WAIVER SERVICES

To provide a smooth transition for Participants who are moving out of PRTF Transition Waiver services due to becoming ineligible for waiver services, the following policy must be followed:

- 1) For participants discharging from waiver services due to an increase in level of functioning or becoming ineligible for waiver services, a transition plan must be developed.
- 2) The transition plan will be discussed and developed in the Child and Family Team meeting, as well as documented in the meeting minutes.
- 3) Participant will have up to 90 days (from the date of the CANS assessment indicating the change in Level of Care) to transition from PRTF Transition Waiver services to traditional outpatient or community-based services that may be covered under the Medicaid Rehabilitation Option (MRO) or Medicaid Clinic Option (MCO) for Medicaid recipients.
- 4) Refer to the Policy for *Participant Termination, Interrupt and Re-start* Status (above in this section) for procedure to complete a Data Entry Worksheet (DEW), which is required for any child transitioning out of PRTF Transition Waiver services.

Note: *If Level of Care changes for a Participant and necessitates transition from waiver services, the transition process must not last longer than 90 days from the date of the CANS assessment indicating the change in Level of Care.*

MEDICAID ELIGIBILITY & SERVICE DELIVERY

The Participant must be eligible for a qualified Medicaid category in order to receive waiver services. If a Participant loses Medicaid eligibility, even due to the family failing to submit required information to Medicaid in the time requested, the Participant will not be eligible to receive waiver services.

Due to the impact on a Participant's treatment that losing Medicaid eligibility can have, the Wraparound Facilitator is responsible to assist the family or caregiver in regular monitoring of the Participant's Medicaid eligibility status:

- 1) The Wraparound Facilitator (WF) can become an *Authorized Representative* for the youth they serve through the Department of family Resources (DFR), so they have the authority to coordinate with the DFR to assist Participants/families with any issues that may arise with the Participant's Medicaid eligibility.
- 2) The WF is responsible to verify IHCP Medicaid eligibility with IndianaAIM for each participant prior to delivery of waiver services and notify the other waiver service providers on the team if a change in Medicaid eligibility affects the delivery of waiver services.
- 3) All issues with Medicaid eligibility that are identified by a service provided must be reported immediately to the WF.
- 4) Medicaid eligibility may change from month-to-month; therefore, the WF must verify/re-verify Medicaid eligibility for the Participant as follows:

Note: *The Wraparound Facilitator must verify Participant Medicaid eligibility monthly. Services provided to an ineligible Participant will be denied payment.*

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- a) Prior to delivering the first waiver service;
 - b) Prior to providing the first service each month; and again at mid-month.
- 5) Participants enrolled in the Hoosier Healthwise Managed Care are not eligible for PRTF Transition Waiver services. If the provider determines the Participant is enrolled in Hoosier Healthwise Managed Care, the provider must notify the Wraparound Facilitator immediately.
- 6) If a Participant loses eligibility for Medicaid, the WF must complete a Data Entry Worksheet (DEW) according to procedures noted in the *Participant Termination, Interrupt and Re-Start Status Policy*, placing the Participant on *Interrupt* status. Waiver services provided during this time will not be reimbursable under the Waiver or Medicaid.
- 7) The Participant may remain on *Interrupt* status for up to 30 days. If Medicaid eligibility cannot be reestablished in that time, the WF must terminate waiver services (by completing a DEW form).
- 8) If the Participant regains Medicaid eligibility and wants to return to waiver services before the 30 days of the *Interrupt* status have expired, the WF will complete a *Restart* DEW and waiver service delivery may resume.
- 9) If Participant regains Medicaid eligibility after being terminated from waiver services, and wants to reenroll in waiver services, the following will apply:
- a) The Participant must be re-enrolled within the same federal fiscal year that he/she was terminated from the program (Federal Fiscal Year runs October 1st through September 30th);
 - b) Participant must still meet all eligibility criteria for the PRTF Transition Waiver, as determined by a full assessment (and administration of the CANS if more than 6 months since last CANS assessment) to confirm eligibility and Level of Care criteria required for Participants in waiver services. Refer to *LOC Review & Evaluation* subsection above for additional information.
 - c) If Participant does not receive an assessment to re-enroll in waiver services prior to the end of the Federal Fiscal Year in which he/she was terminated, then he/she is ineligible for PRTF Transition Waiver services and may not reapply for services under the PRTF Transition Waiver.
 - d) For Participants that are authorized by DMHA to reenter waiver services, a *Re-Entry* DEW form must be completed by the Wraparound Facilitator.

SECTION 10: WRAPAROUND SERVICE DELIVERY OVERVIEW

This section is intended to describe the philosophy and framework within which the PRTF Transition Waiver's intensive, home and community-based, wraparound services are provided. The following Wraparound services/interventions may be available to eligible Participants under this waiver, based upon the Participant's needs :

- 1) Wraparound Facilitation
- 2) Wraparound Technician
- 3) Habilitation
- 4) Respite
- 5) Consultative Clinical and Therapeutic Services
- 6) Flex Funds
- 7) Non-Medical Transportation
- 8) Training and Support for Unpaid Caregivers

Manual Sections 13 through Section 20 of this manual describe each of the waiver services and include detailed information regarding the provider types, qualifications, standards and documentation requirements; as well as service rates, units of service and billing codes.

Wraparound, for purposes of this program, is defined as an ecologically-based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports mobilizing resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, resources and strategies.

In order to be most effective, the Wraparound philosophy asserts services and interventions should be family- and youth-driven, individualized, holistic, culturally competent, and based in the community.

The Wraparound practice model is a team-based process for planning and implementing formal and informal services, interventions and supports for youth with complex needs. Services are provided in a manner that is consistent with and guided by a System of Care Philosophy.

A System of Care is a comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of youth and their families; and includes the following concepts regarding care delivery:

- Family-driven and youth guided
- Individualized and community-based
- Culturally and linguistically competent

THE 10 WRAPAROUND PRINCIPLES

DMHA requires that the intensive Wraparound services provided under this waiver adhere to a Wraparound philosophy and are representative of the following Wraparound Principles:

- 1) ***Family Voice and Choice***: Wraparound Team specifically elicits and prioritizes the Participant and family perspectives during all phases of the Wraparound Process. The Team strives to provide options and choices such that the Plan reflects family values and preferences.

- 2) **Team Based:** The Team consists of individuals, agreed upon by the Participant/family, who are committed to them through informal, formal and community support and service relationships.
- 3) **Natural Supports:** The Team encourages the full participation of team members chosen from the family's networks of interpersonal and community relationships.
- 4) **Collaboration:** Team members cooperate and share responsibility for developing, implementing, monitoring and evaluating a single wraparound Plan of Care (POC). The plan reflects a blending of team members' perspectives, mandates and resources. The Plan guides and coordinates each team member's work towards meeting the Team's goals.
- 5) **Community-Based:** The Team implements services and supports that take place in the most inclusive, responsive, accessible and least restrictive settings possible that safely promote Participant and family integration into home and community life.
- 6) **Culturally Competent:** The Wraparound Process respects and builds on the values, preferences, beliefs, culture, and identity of the Participant/family and their community. Non-family Team members refrain from imposing personal values on the POC.
- 7) **Individualized:** The Team develops and implements customized strategies, supports and services to achieve the goals laid out in the POC.
- 8) **Strengths-based:** Both the Wraparound Process and POC identify, build on, and enhance the capabilities, knowledge, skills, and assets of the Participant/family, their community and the other team members.
- 9) **Persistence:** Regardless of challenges that may occur, the Team persists in working toward the goals included in the POC until the Team agrees that a formal Wraparound Process is no longer required.
- 10) **Outcome-Based:** The goals and strategies of the Plan are tied directly to observable or measurable indicators of success. The Team monitors progress in terms of these indicators and revises the POC accordingly.

The Wraparound Philosophy asserts that, to be most effective, services should be family- and youth-driven, individualized and holistic, culturally competent, and based in community.

THE CHILD & FAMILY WRAPAROUND TEAM

The PRTF Transition Waiver services program includes the delivery of coordinated, highly individualized Wraparound services and interventions that address the Participant's unique needs; build upon the Participant and family strengths; and assist the Participant and family in achieving more positive outcomes in their lives.

Wraparound services and interventions are provided by qualified, specially trained service providers who engage the Participant and family in a unique assessment and treatment planning process characterized by the formation of a Child and Family Wraparound Team.

The Child and Family Team is developed by the Participant and family to provide the support and resources needed to assist in developing and implementing an individualized Plan of Care. Members of the Child and Family Team may include, but are not limited to:

- 1) The Participant and family, who will drive the treatment planning process;
- 2) The Wraparound Facilitator, who will coordinate service delivery and assist Participant and family in linking with community and natural supports;
- 3) Waiver service providers and Non-Waiver community providers who will provide the Participant and family with resources and supports in the treatment process; and
- 4) Any other individual(s) Participant/family selects to support and/or assist them in implementation of the Plan of Care.

THE FOUR STAGES OF THE WRAPAROUND PROCESS

The PRTF Transition Waiver service delivery model will follow the Four Phases of the Wraparound Process. It is important to note that the phases are fluid and not necessarily followed in a strictly linear fashion. The needs of the Participant and family dictate the course of the treatment process. The following phases are observed:

- 1) **Phase One: Engagement.** This phase begins the Wraparound process for the Participant and family. The Wraparound Facilitator educates the Participant and family about the team process and waiver services, as well as assists them with identifying the Child and Family Team members. The initial Child and Family Team meeting is scheduled and held to begin the treatment process. It is in this Phase that the family shares their life story and their vision for how their lives will look after treatment.
- 2) **Phase Two: Plan Development.** This Phase involves the Wraparound Facilitator and Child and Family Team working together to develop the POC. Wraparound Facilitation is the strategy used to organize and coordinate the design and delivery of all interventions and services. The Child and Family Team develop a plan for coordinating efforts and resources that results in a unified intervention plan to meet the unique needs of the Participant. The POC services may be diverse and cross a number of life-domains, including family support, behavior management, therapy, school-related services, habilitation, medical services, crisis services, and independent and interpersonal skills development.
- 3) **Phase Three: Implementation, Monitoring and Outcomes.** This phase is marked by the members of the Child and Family Team engaging in service delivery, support and/or ongoing monitoring and evaluation after the POC is implemented. The Child and Family Team meetings are one way in which the effectiveness of the POC is assessed and modified, if needed. The POC specifies who is responsible for each intervention or service and who is responsible for on-going monitoring of the plan. The Wraparound Facilitator is ultimately responsible for all plan development, implementation, and monitoring, including knowledge of when the Participant and/or family needs or preferences change.

- 4) **Phase Four (final phase): Transition Phase.** This phase begins when the Child and Family Team agrees that the identified needs have been addressed and the Participant/family is ready to transition out of waiver services. The Wraparound Facilitator helps the Child and Family Team develop a transition plan for the Participant/family. This plan addresses the Participant and family strengths and includes any remaining needs that to be addressed in a less intensive level of care. The Team also identifies resources that will continue to be available to the Participant/family after waiver services have ended. It is important to note that while the final transition planning occurs at the end of treatment, the initial steps in developing the transition plan occur at the beginning of treatment and POC development when the Child and Family Team is exploring the Participant and family vision for life after waiver services. The transition plan is the desired next step after waiver services; and is based upon the Participant and family's desires and preferences.

WRAPAROUND FIDELITY INDEX

One way that the State will assess whether the Participant/family is being appropriately supported in the Wraparound process, and has the authority to determine who will be involved in the treatment process, is through the use of the Wraparound Fidelity Index.

The Wraparound Fidelity Index 4.0 (WFI-4) is a set of four interviews that measure the nature of the Wraparound process that the Participant/family receives. The WFI-4 is completed through brief, confidential telephone or face-to-face interviews with four types of respondents: caregivers, youth (11 years of age or older), Wraparound Facilitators, and team members. It is important to gain the unique perspectives of all these informants to understand fully how Wraparound is being implemented; how the team interacts and works together to come up with solutions; and how the team is working toward successfully completing the program. In each interview, questions are asked about all parts of the wraparound process. A demographic form is also part of the WFI-4 battery.

The WFI-4 interviews are organized by the four phases of the Wraparound process (e.g., Engagement and Team Preparation, Initial Planning, Implementation, and Transition). In addition, the 40 items of the WFI interview are keyed to the 10 principles of the Wraparound process, with four items dedicated to each principle. In this way, the WFI-4 interviews are intended to assess both conformance to the Wraparound practice model, as well as adherence to the principles of Wraparound in service delivery.

The WFI-4 survey assists DMHA in determining whether the services families receive are being delivered according to the 10 principles of Wraparound. Indiana has evidence that closer adherence to the Wraparound model improves outcomes for youth and families. Therefore, using information from the WFI-4 provides DMHA and service providers information about outcomes and potential areas for process improvement and/or technical assistance. The reports are in aggregate, summary form; and the information is used locally and state-wide to help improve services and outcomes.

SERVICE PLAN IMPLEMENTATION & MONITORING

The Wraparound Facilitator (WF) is responsible to monitor and oversee the implementation of the Plan of Care (POC). The WF will facilitate at least one monthly Child and Family Team meeting.

Service providers become members of the Team in addition to other members identified by the family. In each team meeting, current concerns of the Participant and family, treatment progress, implementation of the POC and Crisis Plan are reviewed.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

On a weekly basis or, more often as needed, the WF is in contact with the family through home or community-based visits or by phone to monitor Participant's treatment progress, implementation of the POC and address immediate Participant/family needs. The WF also remains in frequent contact with the other service providers to coordinate care and monitor progress and implementation of the POC. During each of these contacts, monitoring includes assessment of the POC implementation, as well as the welfare and safety of the Participant.

SECTION 11: PLAN OF CARE

The Plan of Care (POC) is a written document that is developed by the Child and Family Team, with active input and participation from the Participant/family. The POC is the blending of team member perspectives, mandates and resources; and is based on Participant and family strengths, needs, preferences, values and culture. The key components of the POC include:

- 1) *Needs*: What is missing/what does the participant/family want?
- 2) *Goals*: How will participant/family and team know needs are being met?
- 3) *Interventions*: How do we get there? What is needed to assist participant/family in meeting needs and achieving their POC goals?

The individualized POC guides a Participant's treatment in the PRTF Transition Waiver program. The policies and procedures in this section outline the Wraparound Facilitator and Child and Family Team member responsibilities associated with the development and implementation of the POC.

INDIVIDUALIZED PLAN OF CARE POLICY

The Plan of Care (POC) is an individualized treatment plan that integrates all components and aspects of care that are deemed medically necessary/clinically indicated and includes goals that delineate the following:

- 1) Clear objectives.
- 2) Resources (Child and Family Team members that will assist Participant in meeting a goal).
- 3) Service(s), including the duration and frequency of service delivery based upon the Participant's needs and functional impairments.
- 4) Defines the roles and responsibilities of the Child and Family Team members.

Note: POC must include all indicated medical and behavioral support services needed by the Participant.

The POC must include all indicated medical and behavioral support services needed by the Participant in order to assist him/her in the following:

- 1) To remain in the home/community;
- 2) Function at the highest level of independence possible; and
- 3) Achieve treatment goals.

Additionally, the POC must meet the following requirements:

- 1) Be developed for each Participant based upon his/her unique strengths and needs, as ascertained in the evaluation/assessment.
- 2) Delineate services that will be provided in the most appropriate setting to achieve the Participant's and family's goals.
- 3) Be developed with the Participant, family and Child and Family Team member input and participation.

- 4) Reflect the Participant and family preferences and choices for treatment and service providers.
- 5) Includes a Crisis Plan (*Refer to the Crisis Plan Policy in Manual Section #12 for additional information about the creation of the Crisis Plan*).

The POC and Crisis Plan must be submitted to DMHA for review and approval prior to commencing with delivery of waiver services. The POC is continually monitored and evaluated by members of the Child and Family Team, to ensure that it reflects the family's preferences and supports the strengths and needs of the Participant. The Child and Family Team meetings provide a forum to discuss the appropriateness of the POC and determine when POC updates are indicated. Any change to the POC, if indicated, must be approved by DMHA prior to implementation.

PARTICIPANT FREEDOM OF CHOICE POLICY

The Participant and family have the *freedom of choice* regarding the following aspects of waiver services:

- 1) Choice regarding the POC goals and method for achieving those goals;
- 2) Choice regarding the waiver services accessed, as supported by the Participant's CANS assessment, service intensity needs, and DMHA approved POC;
- 3) Choice of DMHA-approved waiver service provider(s) and Wraparound Facilitator providing waiver services; and
- 4) Freedom to change waiver service provider(s) and/or Wraparound Facilitator anytime during enrollment in PRTF Transition Waiver services program.

PLAN OF CARE DEVELOPMENT PROCESS AND GUIDELINES

Each Plan of Care (POC) is a functional, dynamic tool that describes the Participant's strengths, needs, treatment goals and interventions. The POC is developed within the Child and Family Team with input and agreement from all team members; and must be monitored and updated, as needs are addressed or change. It serves as the primary communication tool between the Wraparound Facilitator (WF) and the State regarding the Participant's status and progress in treatment while enrolled in waiver services.

The Cost Comparison Budget (CCB), which is a product of the POC, is the POC format in INsite documenting all authorized waiver services, units of service, the allocation of funding for the specified services and the provider(s) of each service. This is the basis of the authorization of services and issuance of the Notice of Action (NOA). *Refer to Manual Section #6 Claims and Billing for additional information about the NOA.*

Note: *The POC Development process and guidelines outlined in this manual continue the process that waiver participants underwent while on the CA-PRTF Grant. These are adhered to as a part of the ongoing process of review and evaluation of the youth's progress in treatment to ensure the POC goals and interventions adequately represent the youth's strengths and address his/her identified needs.*

The POC/CCB development begins with the Child and Family Team (CFT) who engages the Participant and family in the POC/CCB development process. The process includes the following components:

CANS ASSESSMENT REVIEW

The Child and Family Team will review and discuss results from the most recent administration of the Child and Adolescent Needs and Strengths (CANS) assessment tool. This step will assist the Team in beginning to identify the strengths and needs of the Participant and family.

IDENTIFYING FUNCTIONAL STRENGTHS

Identification of the Participant's functional strengths is one of the first steps in each POC development process as it provides the foundation upon which to build an effective POC. Functional strengths are more than just adjectives describing the likeable aspects of the Participant's personality. They represent what makes the Participant unique and assists him/her in functioning and enjoying life. Strengths are defined as interests, talents and unique contributions that make life better for the family. They are to be described in the POC as more than just adjectives. (*For example:* Instead of stating the Participant is patient; the team might say the Participant is patient when working with small children. Instead of saying the Participant is athletic; the team might say the Participant enjoys playing soccer).

Also included in the identification of strengths is noting the resources the family possesses that can assist in helping the Participant reach their POC goals (e.g., relationships in the community, supportive expanded family, etc.).

One way the Team identifies the Participant's functional strengths is to discuss and answer the following types of questions:

- 1) Describe how the Participant brings some joy to the family.
- 2) Who has been the most help and support during difficult times?
- 3) What is the Participant/family most proud of in regards to how they have handled the Participant's needs?
- 4) What has the Participant and/or the family (or previous professionals) done to help the Participant gain those skills?
- 5) What is the Participant/family viewpoint on how well previous treatment efforts have worked?
- 6) If Participant/family did not have the PRTF Transition Waiver to help, what would they do to achieve their dream/goal?
- 7) What does the family do for the Participant and what does the family assume he/she can do for him/herself?

IDENTIFYING UNDERLYING NEEDS

The services and interventions selected by the Participant and family are driven by the Participant's needs, as determined by the Child and Family Team (CFT) and data collected from the administration of the CANS assessment tool. Needs define the underlying reasons why behaviors happen in a given situation.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

The process of identifying underlying needs was initially used by the Wraparound Facilitator to develop the participants CA-PRTF Grant POC; and will also be used to determine a PRTF Transition Waiver participant's POC needs (for those Participants meeting eligibility to continue to receive PRTF Transition Waiver services).

Initially, the WF met with the family to learn the family's story and the full timeline of events that led them to requesting the enrollment in CA-PRTF Grant services. The intent of learning the family's story was to uncover the Participant's underlying needs, those needs that if met would result in a positive change in Participant behaviors and choices. The WF developed and presented to the Child and Family Team a list of empathetic statements regarding their understanding of the family story and the Participant and family's underlying needs. The family decided whether or not the statements fit or described the Participant's and family's needs and should be addressed in the Wraparound process and Plan of Care. If the Participant and family did not accept the WF's empathetic statements as descriptive of the Participant's needs, the process of learning more about the family story, the Participant's underlying needs and the development of empathetic statements began again; until there was family agreement on the needs that should be addressed to help them reach their family goal or vision.

A similar process is followed at the time a POC review and/or update is needed for an eligible PRTF Transition Waiver participant.

The following guidelines should be remembered during the needs identification process:

- 1) Needs are based on *what is missing?* (i.e., hope, awareness, courage, strength, knowledge, family stability; self-esteem, etc.).
- 2) When discussing needs with the Participant/family, use clear meaningful facts.
- 3) Underlying needs are grounded in the context of the family story.
- 4) Needs do not equal services and must never be documented on the POC as a list of directives.
- 5) The CFT may have to prioritize the list (short-term vs. long-term and crisis needs) to narrow the list of needs down to a number that can be reasonably addressed on the immediate POC.
- 6) Focus on the big issues first, and then break these down into workable components. Drill down into each need to help get to a much deeper understanding of the underlying need by recognizing as many factors as possible that contribute to it. This prompts the Participant, family, and CFT to think of information that had not initially been associated with the need. It also shows exactly where additional information may be required in order to fully understand the underlying need.

Note: Needs must never be documented on the POC as directives or the sole basis for receiving a service.

Check out this useful root-cause analysis and problem solving tool that is useful in drilling down and identifying underlying needs:

http://www.mindtools.com/pages/article/newTMC_5W.htm

DEVELOPING TREATMENT GOALS

The development of the POC treatment goals is driven by the family's *Vision*—which is what they hope to gain from the Wraparound process. The CFT assists the family in identifying and describing their current vision and supports the process by upholding the team mission statement—which is how the members of the team see their role in the wraparound process and in assisting the family in realizing their vision. The following guidelines are used by the CFT in the development of the POC goals:

- 1) The CFT works with Participant/family to identify what their Vision is for the short-term and the long-term.
- 2) A formal statement of the Participant and family's hopes, dreams, aspirations and direction is developed.
- 3) The CFT acknowledges the POC is a *living* document subject to change dependent upon the changes in the family status and/or the Participant's response to treatment.
- 4) For each *Underlying Need* that has been identified, the CFT will document at least one *Goal* to address that need.
- 5) The family/Participant must have buy-in of the goals developed for the POC.
- 6) The POC development process should never be interpreted as a punishment.
- 7) Goals may be identified as *short-term*, *incremental improvement* or *long-term* for the life of the POC.
- 8) Goals must be realistic and achievable; otherwise the Goal will likely set up the Participant/family for failure. (e.g., Participant will attend school 100% of the time for next 3 months—this goal will likely lead to failure. Instead, an alternate goal might be: Participant will not miss more than 3 days per month for the next 90 days based on school attendance records—a goal more likely to be attained).
- 9) Each Goal must be measurable to enable the CFT to be able to identify success (or lack of success) in meeting the POC goal. The WF and CFT must be able to track POC progress, or issues/barriers related to progress, so the POC can be adjusted to better assist the Participant and family in achieving positive outcomes.

CHOOSING WAIVER SERVICES & INTERVENTIONS

For each identified Need/Goal documented on the POC, there must be at least one service or intervention identified to address the need and assist the Participant in meeting the goal. The POC must identify all services (waiver/non-waiver) and interventions the CFT agrees is needed to assist the Participant/family in obtaining the identified POC goals. Interventions may include traditional and/or non-traditional options, such as natural supports, community correction, activities, and etcetera. Interventions must be tied to improving, building, or connecting with functional strengths identified by the CFT.

The following guidelines apply to choosing waiver services and interventions for the POC:

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 1) Services must not be “provider-driven”. All services and interventions are selected by the Participant/family, with assistance of the CFT—and are not to be dictated by the Wraparound Facilitator or service providers on the CFT.
- 2) While the family has freedom to choose which services they want on the POC, the services available for the family to choose from are based upon the Participant’s documented needs from the CANS assessment; and identified and documented by the CFT.
- 3) All waiver services must follow the definitions and limitations specified in the CMS-approved waiver, as well as current Bulletins and other State issued documents. Neither the family, nor service provider can redefine the scope of waiver services.
- 4) The CFT identifies the service intensity/frequency that is necessary to address each need and achieve the established goal. The intensity/utilization of each service/intervention must be based on the Participant’s documented Needs and Goals.
- 5) Family and providers need to be aware that POC services are not meant as permanent interventions and must be evaluated on a regular basis to determine the success of the interventions or need for changes to the POC.

DMHA AUTHORIZATION OF PLAN OF CARE

Prior to implementing the completed POC, the Wraparound Facilitator must submit the POC/CCB to DMHA for review by entering the information into the FSSA electronic waiver management system (INsite). DMHA will review the submitted information and return one of the following Level of Care review determinations via a Notice of Action (NOA):

- 1) **Approval:** An approved POC/CCB will result in a prior authorization for waiver services on the issued NOA. Service providers are emailed a copy of the NOA from the INsite system. The WF has the family sign the NOA (WF copy) and the signed copy is kept in case file.
- 2) **Request for Additional Information:** If DMHA requires additional information in order to adequately review and make a determination regarding the submitted POC/CCB, the WF will be asked to address the concerns, and if needed, submit a revised POC/CCB within another 5 business days. DMHA will review the revised POC within 5 business days of receipt of the updated information.
- 3) **Denial:** DMHA will deny/reject any POC/CCB that does not adequately follow the required *Need/Goal/Intervention*/POC development procedures and requirements described above. If the submitted POC/CCB is denied by DMHA, the WF will need to submit a new POC/CCB and/or documentation for DMHA review within five (5) days of the denial. The WF is responsible to provide the Participant/family with a copy of the NOA.

Note: A DMHA Waiver staff member monitors the POC and CCB approval process to provide technical assistance to providers; and ensure timeliness in submission of waiver- appropriate POCs.

Providers must follow the approved POC and NOA when delivering waiver services for a Participant.

- 1) The WF will be responsible for coordinating the care once the POC/CCB has been approved.

- 2) Service type, frequency and units must not deviate from the approved POC without DMHA prior authorization. If a service provider feels the service(s)/intervention(s)/unit(s) on the POC/NOA does not adequately support the defined *Needs/Goals*, or has any questions on how the service should be provided, the WF and CFT must be notified.
 - a) A revised POC/CCB may be submitted to DMHA for consideration.
 - b) Services rendered outside of the service definitions, or the approved POC/CCB/NOA will not be eligible for reimbursement, and are subject to payback if inappropriately reimbursed.
- 3) The INsite system communicates with the OMPP Medicaid Fiscal Agent contractor system, which processes the Medicaid and PRTF Transition Waiver claims.
 - a) If there is an open POC/CCB in INsite/AIM that CCB will remain in effect until DMHA approves a change.
 - b) If the approved CCB has expired, or any service on that POC has expired, the CCB (or expired service) will not be funded by the PRTF Transition Waiver until a new POC/CCB is approved; and the new NOA is issued.

SERVICE DELIVERY & PLAN OF CARE

The CFT is responsible for continually monitoring and updating the participant-centered POC to ensure it accurately reflects the Participant and family needs and goals. While the WF is responsible for writing the POC, it is developed and finalized with the Participant, family and others in the CFT. The following applies to the implementation and monitoring of the approved POC:

- 1) While the Level of Care is effective for up to one year from the initial/annual approval date, the POC is a fluid document that must be continually evaluated for effectiveness and is updated by the CFT to address the Participant's changing needs and maintain efficacy of treatment and interventions provided.
- 2) In addition to monthly CFT meetings to monitor the POC implementation and progress, a CANS Reassessment is completed as necessary, but not more than 6 months after the initial CANS, to more formally identify progress and areas of changing need.
 - a) This reassessment is facilitated by the WF with the Participant and family, and includes CFT input.
 - b) The semi-annual CANS reassessment may result in a modification to the POC and/or level of care.
- 3) If any service authorized on the NOA needs to be changed due to a change in the Participant's need for service intensity, the provider is not authorized to make the change without DMHA approval and an updated NOA.
 - a) The provider must notify the Wraparound Facilitator of the need and rationale for a possible change in level of service intensity or needs for service delivery.
 - b) It is the responsibility of the WF and the CFT to determine the need for changes to the Participant's POC.
 - c) When indicated, changes in service delivery must be documented on an updated POC/CCB that's submitted to DMHA for review and approval prior to a change in service delivery.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- d) If the updated POC is approved by DMHA, a revised NOA will be issued with the updated service(s).
- 4) A Level of Care review and assessment is required at least annually. This includes a face-to-face assessment of the Participant for level of care and eligibility for waiver services. See Manual Section 9 for additional information about continuing Participant eligibility for waiver services.

SECTION 12: CRISIS PLAN

Prior to beginning in PRTF Transition Waiver services (and during periods of reassessment), the Participant was assessed and determined to be safe for community-based treatment. However, youth meeting criteria for the waiver services program are at risk and susceptible to crises. To ensure a Participant's safety and successful utilization of waiver services, a Crisis Plan is an important part of the treatment planning process.

This section provides the service provider with information and resources to assist them with the development and implementation of the required Crisis Plan for a Participant in waiver services:

CRISIS PLAN DEVELOPMENT

A Crisis Plan is required for each participant in the PRTF Transition Waiver services program and is developed and entered into INsite at the same time as the POC/CCB. The plan is discussed and developed within the CFT, with emphasis on identifying and defusing situations, ensuring safety, and debriefing crisis situations to maximize the learning opportunity for the Participant and family. The following process is used to assist in developing a comprehensive crisis plan:

- 1) The Plan should reflect the choice and preferences of the Participant/family.
- 2) Potential crises are identified and documented during the POC development process using needs identified on the CANS assessment and family report of past crisis situations.
- 3) Indicators of emerging risks and/or impending crisis and reduced levels of risk are identified in the plan.
- 4) Strategies to which the Participant has responded well in the past are noted, as well as action steps to prevent or mitigate the crisis.
- 5) Action steps include identifying the responsible person(s) for each particular action noted on the crisis plan, including a back-up/contingency plan if the identified resource/individual cannot be accessed during the crisis.
- 6) Specific waiver services may be added to the POC to build coping skills, defuse or provide support during a crisis.
- 7) Other community resources and supports are identified and included in the Crisis Plan.
- 8) The Crisis Plan/Emergency Backup Plan must clearly define the roles of each team member, including family, natural supports, and formal supports.

"It is critical that the potential reinforcing value of successfully resolving crisis for professionals be considered in providing services to children and families.

Further, children and families can often be reinforced by the team attention and support they receive during crisis episodes.

The child and family team should continually reevaluate crisis situations experienced by participant/family to assure this is not occurring."

--Setting the Expectation for Unconditional Care; by Patricia Miles

MAINTENANCE OF THE CRISIS PLAN

The Crisis Plan/Emergency Backup Plan is an integral part of the overall Plan of Care. Effectiveness must be routinely monitored and reviewed at every CFT meeting. The plan is evaluated to ensure it is workable for the family, keeping Participant/family strengths in mind when assisting with challenges/crisis. Changes will be made as needed or requested by the family and CFT. When changes to the crisis plan are made, the WF will enter the updates in INsite to ensure all team members and providers have the most up to date documentation to support the family in the event of a crisis.

In the event that a crisis does occur, the CFT should wait at least 72 hours after the crisis event to make any significant changes to the POC and crisis plan. The next CFT meeting must include a review of the successes or the challenges of the current plan and include any necessary changes. At that point, the plan can be modified to assure that the needed additional skills/resources are provided to the family in the event of another crisis. This builds the basis for future stability for the family.

Seclusion and restraint are not allowed interventions in the Crisis Plan. If an unauthorized seclusion, restraint or restrictive intervention is used, an incident report to DMHA is required (Refer to *Manual Section 21* for additional information regarding the Incident Reporting Policy). This automatically triggers a review of the Crisis Plan and POC and re-evaluation of the Team's ability to safely serve the participant through intensive community-based services. The WF documents the review and update, if needed of the Crisis Plan/Emergency Backup Plan and distributes a copy to all team members.

Features of Effective Crisis Plans

(Excerpt from *Crisis Plans: Setting the Expectation for Unconditional Care*; by Patricia Miles)

- 1) Effective crisis plans anticipate crises based on past knowledge. The best predictor of future behavior is past behavior.
- 2) Great crisis plans assume the "worst case" scenario and plan accordingly.
- 3) While building the crisis plan, remember to research past crises for antecedent, precipitant, and consequent behaviors.
- 4) Effective plans incorporate child and family outcomes as benchmarks or measures of when the crisis is over.
- 5) Good crisis plans acknowledge and build on the fact that crisis is a process with a beginning, middle, and an end rather than just a simple event.
- 6) Crisis plans change over time based on what is known to be effective.
- 7) Clearly negotiated crisis plans, with clear behavioral benchmarks, help teams function in difficult times.
- 8) Behavioral benchmarks, (# runs, # stitches in a cut, etc.) need to change over time to reflect progress and changing capacities and expectations of the youth and family.

Additional resource information, including useful forms can be found by visiting:

<http://www.nwi.pdx.edu/files/WAMilwaukeeMyersCrisisPlanExpect.pdf>

SECTION 13: WRAPAROUND FACILITATION SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|--------------------------------|-------------------------|---|---|---------------|--|
| <i>Wraparound Facilitation</i> | H2021 U7 U1 | Community-Based Wrap around services, per 15 minutes. U1 = Facilitator | \$28.75 per unit. 1 unit = 15 minutes. | One-to-one | None |

Note: Refer to Manual Section 6 for additional claims and billing information.

WRAPAROUND FACILITATION SERVICES DEFINITION

Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry-out the wraparound process (Refer to *Manual Section 10, Wraparound Service Delivery Overview* for additional information about the Wraparound process). Wraparound Facilitation is an important and required component of the PRTF Transition Waiver services program.

Wraparound is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible to assure that the Participant's needs, and the entities responsible for addressing them, are identified in a written Plan of Care.

The individual who facilitates and supervises this process is the Wraparound Facilitator (WF). Each WF will maintain a caseload of no more than 10 youth, regardless of source(s) of funding (waiver, local system of care, etc.). Refer to *Manual Section 10 Wraparound Service Delivery Overview*, for more information about the Wraparound principles and process for service delivery.

Waiver services are authorized for payment based on the Plan of Care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values.

The Wraparound model involves 4 Stages of Wraparound (Miles, Brunes, Osher & Walker, 2006). The 4 stages of wraparound are not linear stages that are necessarily progressed through by the participant and family in a specific order or at a predictable pace. The WF is responsible assess what stage the participant/family is in and needs to progress to in order to facilitate positive outcomes. The WF will guide the Participant, family and Child and Family Team through these stages, as follows:

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 1) **Engagement:** The participant and family are supported by the WF. Together they explore the family's strengths, needs, and culture. They talk about what has worked in the past and what they expect from the wraparound process. The WF engages other team members identified by the family to be members on the Child and Family Team. While engagement is the initial stage a participant and family engage in with the WF, this stage can repeat throughout the entire treatment process (e.g., new WF selected by family; family disengages from treatment process and need to be re-engaged, etc.).

- 2) **Planning:** The WF informs the team members about the family's strengths, needs, and vision for the future. The wraparound team does not meet without the family present. The team, led by the Participant/family preferences, decides what to work on, how the work will be accomplished; and who is responsible for each task. Plan of Care (POC) development is facilitated by the WF. The WF is responsible to write the POC and obtain approval of the POC from DMHA. The WF also facilitates a plan to manage crises that may occur.

- 3) **Implementation:** Family and team members meet regularly (at least monthly). Meetings are facilitated by the WF, who also assures that the family guides the Child and Family Team meetings. The team reviews accomplishments and progress toward goals and makes adjustments, as needed. Family and team members work together to implement the plan.

- 4) **Transition:** As the family team nears completion of the Plan of Care goals, preparations are made for the family to transition out of formal Wraparound Waiver services. The family and team decide how the Participant and family will continue to get support, when needed, and how wraparound can be re-started, if necessary.

WRAPAROUND FACILITATOR- PROVIDER QUALIFICATIONS & STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|---|-----------------------|-----------------------------|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | NO | NO |
| <i>License</i> | The individual providing the Wraparound Facilitation service must meet standards in the <i>Other Standard</i> section. | NA | NA |
| <i>Certificate</i> | Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1). Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA. | NA | NA |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|--|-----------------------|-----------------------------|
| <i>Other Standards</i> | <p>Individuals providing this services must be affiliated with an CMHW-certified accredited agency that adheres to the following standards:</p> <ol style="list-style-type: none"> 1) Agency participates in a local System of Care, which includes both a governing coalition and service delivery system that endorses the values and principles of Wraparound; or in the event the area of the State does not have an organized System of Care, provider is a part of a DMHA-authorized/designated Access Site for Services. 2) Agency must maintain documentation that the individual providing the service meets the following standards: <ol style="list-style-type: none"> a) Qualifies as an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d); or a Bachelor's degree in a human service field with a minimum of 3 years of clinical or management experience in human service related field; and demonstrated 2 or more years of clinical intervention skills. b) Individual has completed and submitted proof of the following screens: <ol style="list-style-type: none"> i) Finger-print based national and state criminal history background screen; ii) Local law enforcement screen; iii) State and local Department of Child Services abuse registry screen; and iv) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 3) All approved providers must complete DMHA and OMPP approved training and certification for waiver services. | NA | NA |

ACTIVITIES ALLOWED

PRTF Waiver services are authorized for payment based on the plan of care. The WF assures that care is delivered in a manner consistent with strength-based, family driven, and culturally competent values. The Wraparound Facilitator is responsible for the following reimbursable activities:

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 1) Completing a comprehensive re-assessment of the individual at least annually. If the WF is not an Other Behavioral Health Professional (OBHP), as defined in 405 IAC 5-21.5-1(d), he/she arranges for a OBHP to complete the annual PRTF LOC re-evaluations with active involvement of the Child and Family Wraparound Team;
- 2) Working in full partnership with team members to develop a revised and annual plan of care.
- 3) Overseeing implementation of the revised plan.
- 4) Identifying providers of services or family-based resources;
- 5) Facilitating Child and Family Team meetings;
- 6) Monitoring all services authorized for a child's care.
- 7) Offers consultation and education to all providers regarding the values and principles of the model;
- 8) Monitors progress toward treatment goals;
- 9) Ensures that necessary data for quality evaluation is gathered and recorded; and
- 10) Ensures that all PRTF Waiver related documentation is gathered and reported to DMHA as per requirements.
- 11) Completes CANS Reassessments every six months to monitor progress.
- 12) Guides the engagement process by exploring and assessing strengths and needs.
- 13) Facilitates, coordinates, and attends family and team meetings.
- 14) Guides the planning process by informing the team of the family vision (no team meeting without family).
- 15) Guides the crisis plan development, monitors the implementation and may intervene during a crisis.
- 16) Authorizes and manages Flex Funding as identified in the Plan of Care.
- 17) Assures that the work to be done is identified and assigned to a team member.
- 18) Assures that the written Plan of Care that was developed, written and approved by the Division of Mental Health and Addiction under the prior existing CA-PRTF Grant is appropriate for continuation under the PRTF Waiver.
- 19) Reassesses, amends, and secures on-going approval of Plan of Care.
- 20) Communicates and coordinates with local Division of Family Resources (DFR) regarding continued Medicaid eligibility status.
- 21) Monitors cost-effectiveness of Medicaid services.
- 22) Monitors and supervises the Wraparound Technician.
- 23) Guides the transition of the youth from the PRTF Waiver.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Wraparound Facilitation Service:

- 1) Duplicative services covered under the Medicaid State Plan.
- 2) Billing for time spent completing the Monthly Report.
- 3) Any waiver service other than Wraparound Facilitation.

SERVICE DELIVERY STANDARDS

The Wraparound Facilitator is responsible for ensuring the waiver services are provided within the framework of Wraparound Principles and according to a Systems of Care philosophy, as well as ensuring the following:

- 1) All waiver services provided meet the standards and regulations for the Medicaid/State-approved waiver.
- 2) There are no service limitations to the quantity of WF services. All services provided must be supported by the participant's plan of care.

- 3) Services are linked to a Need identified through the CANS and CFT process, and are documented on the POC and authorized by DMHA with a current NOA.
- 4) Services are provided in the Participant's home, school, or community as described in the POC.
- 5) Coordinating and facilitating the CFT meetings.
- 6) Wraparound Facilitators are not to bill any other funding source than the waiver when working with the Participant.
- 7) WF will maintain a caseload of no more than 10 children, regardless of source(s) of funding (e.g., grant, local system of care, etc.).
- 8) Wraparound Facilitation does not duplicate Wraparound Technician services or any other Grant or state plan Medicaid service. Every child/family will have a WF. The WF may perform the tasks identified for a Wraparound Technician. This will occur when the caseload does not warrant an added person to perform all the duties of the Wraparound Technician. Both WF and Wraparound Technician services include assistance to participants in gaining access to services (PRTF Waiver, medical, social, educational and other needed services). The difference between these two services is related to the complexity of the activities. The WF manages the entire wraparound process and ensures that all reassessments are completed; ensures that the plan of care is completed (including a crisis plan) and is approved; guides all team members to ensure that the family vision is central to all services; manages the flex fund; and supervises the Wraparound Technician.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*.

Wraparound Facilitators bear the largest portion of documentation requirements, as well as the responsibility for maintaining records of service documentation from all providers on the Child and Family Team. The Wraparound Facilitator must document each contact with, or activity on behalf of, the Participant.

Wraparound Facilitator documentation can be categorized into four primary groups described below:

- 1) INsite documentation
- 2) Team documentation
- 3) CANS documentation
- 4) Agency-related documentation

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

INSITE-RELATED DOCUMENTATION

- 1) Plan of Care (POC) documentation and updates reflecting needs, goals, and interventions, regardless of service source or funding.
- 2) The Crisis Plan is maintained in INsite and regularly reviewed and updated to reflect the Participant's likely crises and the planned interventions. Documentation must include:
 - a) Potential crises

- b) Strategies to which the participant has responded positively or negatively in the past
 - c) Action steps to mitigate or prevent the crisis
 - d) Responsible party for specific action steps
 - e) Other community resources and supports.
- 3) Level of Care (LOC) is routinely assessed and documented to reflect increases or decreases in the functioning and service level of the Participant and determine continued eligibility for waiver services through the following processes;
- a) Monitored every 6 months through administration of the CANS assessment to monitor Participant functioning and service(s) effectiveness; and
 - b) Re-evaluated at least yearly with a face-to-face evaluation and administration of the CANS to determine continued eligibility for a Participant in the waiver services program.
- 4) POC Services are entered into INsite and monitored by the WF.
- a) Notice of Action (NOA) is generated after DMHA reviews and approves/denies the information entered into INsite.
 - b) WF ensures family receives and signs a copy of the NOA. The signed NOA must be retained in the Participant's record.
- 5) Freedom of Choice must be documented in INsite. WF maintains a signed and dated copy of the Freedom of Choice form in the case file.
- 6) Choice of Service Providers: WF must provide Participant/family with the Provider Pick List documented in INsite. WF maintains a signed record in the Participant's file that the Participant/family received a choice of providers.
- 7) Change in Placement must be clearly documented in INsite with a Data Entry Worksheet (DEW).
- a) Change in Placement is defined as the participant being removed from the current residence for more than 24 hours regardless of reason (e.g., acute hospitalization, admission to PRTF, visiting family out of town, placed in juvenile detention, attending camp, etc.).
 - b) The DEW will reflect an *Interrupt* (change in placement estimated to be less than 30 days) or *Termination* (change in placement estimated to be greater than 30 days) from services depending upon the reason for the change in placement.
 - i) NOTE: Respite care is not considered a change in placement.
 - ii) If a participant remains on Interrupt Status for more than 30 days waiver services will be terminated.
 - c) Refer to Manual *Section 9: Participant Eligibility* (Subsection: *Participant Termination, Interrupt, Restart and Reentry Status*) for additional procedural information regarding changes in placement, DEW completion and continued Participant eligibility.

CHILD AND FAMILY TEAM-RELATED DOCUMENTATION

- 1) Team meetings are documented in two ways: *Pre-meeting* and *Post-meeting*.
- a) Pre-meeting documentation includes preparing and distributing an *agenda* to all Team members. The agenda should summarize topics from the last meeting, set guidelines for format and identify potential topics for the upcoming meeting.

- b) Post-meeting Documentation includes preparing a *report* or *minutes* to document the content and plans reached through the Team meeting. This report documents specific actions to be taken by each Team member before the next Team meeting. If services outlined on the POC were not provided, the Wraparound Facilitator must note in the meeting minutes the reason they were not provided and the strategy for correction. Copies of the minutes must be kept with the case file and distributed to all Team members.
- 2) Any other documentation related to the progress or functioning of the Team must be included in the primary file maintained by the WF.

CANS-RELATED DOCUMENTATION

The WF will complete and enter results of CANS assessments in the Data Assessment Registry Mental Health and Addiction (DARMHA) and copies of the assessments must be part of the case file.

AGENCY-RELATED DOCUMENTATION

Each community service agency may require documentation on the case, in addition to what is required by DMHA. The Wraparound Facilitator will be responsible for maintaining this documentation.

BILLING INSTRUCTIONS

Refer to Table “*Description of Service Code and Billing*” at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under “*Activities Not Allowed*” for this service.

Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

SECTION 14: WRAPAROUND TECHNICIAN SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|------------------------------|-------------------------|---|---|---------------|---|
| <i>Wraparound Technician</i> | H2021 U7 U2 | Community Based wrap around service, per 15 minutes, Technical Component U2= Technician | \$23.53 per unit. 1 unit = 15 minutes. | One-to-one | None |

Note: Refer to Manual Section 6 for additional claims and billing information.

WRAPAROUND TECHNICIAN SERVICES DEFINITION

The Wraparound Technician applies the theories and concepts of the Wraparound process and the resulting Plan of Care to the Participant's day-to-day activities. The Wraparound Technician is a supplemental service to the Wraparound Facilitator when caseload sizes/acuity of Participants in the same region are high and an additional service provider is required to meet all of the Wraparound Facilitator responsibilities.

This provider is guided and supervised by the Wraparound Facilitator. The Wraparound Technician will discuss Participant treatment progress with other team members, providers, and family and make recommendations to the Wraparound Facilitator and team. They are also assisting in monitoring service delivery and assisting in linking the Participant/family to resources.

The additional support of a Wraparound Technician is not always required and the need for this supplemental provider will be determined by the Wraparound Facilitator.

WRAPAROUND TECHNICIAN PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|-------------------|-----------------------|-----------------------------|
| <i>Provider Type Eligible to Bill for Service (Yes</i> | Yes | Yes | NO |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|---|--|-----------------------------|
| or No) | | | |
| <i>License</i> | None | None | NA |
| <i>Certificate</i> | <p>Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1).</p> <p>Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.</p> | <p>Agency already in process of accreditation by one the approved accrediting bodies for an Accredited Agency; plus three (3) years experience under the same agency name serving children with SED/youth with SMI; or</p> <p>An agency registered with the State of Indiana as a Professional Corporation plus three (3) years experience under the same agency name serving children with SED/youth with SMI; or</p> <p>An agency that has four (4) years experience under the same agency name working with children with SED/youth with SMI.</p> | NA |
| <i>Other Standards</i> | <p>Accredited and Non-Accredited agencies must receive approval from DMHA, based on qualifications of individuals providing services. Agency must also meet the following:</p> <ol style="list-style-type: none"> 1) Participation in a local System of Care, which includes both a governing coalition and service delivery system that endorses the values and principles of a System of Care. 2) Maintain documentation (Non-Accredited agency must submit documentation to DMHA) demonstrating the individual Wraparound Technicians meet the following standards: <ol style="list-style-type: none"> a) Bachelor's degree in human services or related field; and b) A minimum of 1 year full-time, paid, DMHA approved work experience in providing services to children with serious emotional disturbances (SED) and/or youth aged 18 through 20 with a serious mental illness (SMI), including assessment, care plan development, linking services, and monitoring. c) Finger-print based national and state criminal history background screen; | | NA |

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|---|-----------------------|-----------------------------|
| | d) Local law enforcement screen e) State and local Department of Child Services abuse registry screen; and f) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a) (1). 3) Complete DMHA and OMPP approved training and certifications. | | |

ACTIVITIES ALLOWED

The following activities are eligible for reimbursement by a Wraparound Technician:

- 1) Monitor progress by communicating with the Participant and family, as well other team members and the Wraparound Facilitator. The timetable for and the mode of communication should be determined with the family.
- 2) Assist the Participant and family with gaining access to services and assure that families are aware of available community-based services and other resources, such as Medicaid State Plan services, Vocational Rehabilitation programs, educational, and public assistance programs.
- 3) Monitor use of service and engage in activities that enhance access to care, improve efficiency and continuity of services, and prevent inappropriate use of services.
- 4) Monitor health and welfare of the Participant.
- 5) May be a part of the Crisis Plan and/or provide crisis intervention, if needed.
- 6) With DMHA approval, facilitate and document Child and Family Team meeting if Wraparound Facilitator is unavailable (i.e., Medical leave).
- 7) May facilitate Medicaid certification and enrollment of potential providers identified by the family to provide waiver services.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Wraparound Technician Service:

- 1) Duplicative services covered under the Medicaid State Plan.
- 2) Billing for time spent completing the Monthly Report.
- 3) May not bill for time in a Child and Family Team meeting, unless facilitating the meeting in lieu of the Wraparound Facilitator.

- 4) Any waiver service other than Wraparound Wraparound/Technician.

SERVICE DELIVERY STANDARDS

The Wraparound Technician is responsible for ensuring the waiver services are provided within the framework of Wraparound Principles and according to a Systems of Care philosophy, as well as ensuring the following:

- 1) All waiver services provided meet the standards and regulations for the Medicaid/State-approved waiver.
- 2) Services are linked to a Need identified through the CANS and CFT process, and are documented on the POC and authorized by DMHA with a current NOA.
- 3) Services are provided in the Participant's home, school, or community as described in the POC.
- 4) Participating in the CFT meetings.
- 5) There are no service limitations to the quantity of WF services. All services provided must be supported by the participant's plan of care.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

BILLING INSTRUCTIONS

Refer to Table "*Description of Service Code and Billing*" at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under "*Activities Not Allowed*" for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

SECTION 15: HABILITATION SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|------------------------------|-------------------------|--|---|---------------|---|
| <i>Habilitation Services</i> | H2014 U7 | Skills training & development, per 15 minutes. | \$19.26 per unit. 1 unit = 15 minutes. | One-to-One* | Max. 12 units (3 hours) daily. Up to 120 units (30 hours) of services/per month. |

Note: Refer to Manual Section 6 for additional claims and billing information.

*Service Ratio Note: In a group situation, the Habilitation provider's services must include only the Participant. The Participant may participate in an activity with one or more other children while receiving Habilitation services from the Habilitation provider, as long as the provider is responsible for only that Participant.

Example: Habilitation may be provided to monitor the Participant's behavior during a martial arts lesson, but another person/instructor must be responsible for all other individuals in that class.

HABILITATION SERVICE DEFINITION

Habilitation services are provided with the goal of enhancing the Participant's level of functioning, quality of life and use of social skills, as well as building Participant and family's strengths, resilience and positive outcomes. Habilitation services are provided face-to-face in the Participant's home or other community-based setting based upon the preferences of the Participant/family.

PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|---|--|-----------------------------|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes Note: Agency must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Accredited | Yes Note: Agency must receive approval from DMHA for an individual to provide this service, based on the qualifications of the individual. Agency must | Yes |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|--|--|-----------------------------|
| | agencies must maintain documentation that individuals providing the service meet service standards and requirements | submit documentation to DMHA demonstrating that individuals providing the service meet the provider service standards and requirements specified in this manual. | |
| <i>License</i> | NA | NA | NA |
| <i>Certificate</i> | Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1). Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA. | NA | NA |
| <i>Other Standards</i> | <p>The following standards are required for a DMHA-certified Habilitation Provider:</p> <ol style="list-style-type: none"> 1) At least 21 years of age; and High school diploma, or equivalent; 2) Three (3) years paid, volunteer or personal experience working with children with serious emotional disturbances (SED), as defined by DMHA (<i>Refer to SED Experience Requirement subsection in Manual Section 3 for additional information</i>). 3) Complete and submit proof of the following screens: <ol style="list-style-type: none"> a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen; c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 4) Completed DMHA and OMPP approved training and certifications. 5) Documentation of safe driving record and maintained vehicle, as well as: <ol style="list-style-type: none"> a) Current Driver's License; and b) Proof of auto insurance coverage. | | |
| <i>*Provider Supervision Requirements</i> | <ol style="list-style-type: none"> 1) Habilitation providers are required to obtain one (1) hour of face-to-face supervision for every thirty (30) hours of habilitation services provided. <ol style="list-style-type: none"> a) Supervision time is not billable to the waiver. | | |

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|--|-----------------------|-----------------------------|
| | <p>b) The supervision time does not need to be completed in a single block of time, but can be split up over the month, as long as the one (1) hour of supervision occurs within 14 days of completing 30 hours of habilitation services.</p> <p>c) Supervision must be obtained from a Health Service Provider in Psychology (HSPP) as defined by IC 25-33-1; Licensed Marriage and Family Therapist (LMFT); Licensed Clinical Social Worker (LCSW); or Licensed Mental Health Counselor (LMHC) under IC 25-23.6.</p> <p>d) It is the responsibility of the Habilitation provider to ensure the supervision is completed, as required.</p> <p>2) Supervisor must not be a member of the Participant's Child and Family Team.</p> <p>3) Supervision must include the following:</p> <p>a) Review of all Participant documentation, such as monthly summaries, progress notes, Child and Family Team Meeting Minutes, treatment goals and progress made towards those goals.</p> <p>b) Discussion about any significant change or event with the Participant's behavior/affect or within the family.</p> <p>4) Supervision must be adequately documented in the Participant's file and meet the following standards:</p> <p>a) Supervision documentation must be documented in a "Supervision Summary Note format" agreed upon by the Habilitation provider and Supervisor.</p> <p>b) The note must be signed by the supervisor, including the date of supervision and credentials of the Supervisor. In signing the note, the Supervisor is verifying that the supervision occurred on a given date and timeframe.</p> <p>c) Documentation of challenges the Habilitation provider has faced and supervisory suggestions for his/her improvement.</p> <p>d) The Supervision role is not intended for Waiver clinical direction on a Participant's case. It is intended to provide coaching and supervision for the Habilitation provider only; and his or her ability to maintain quality outcomes with the Participant on the Waiver.</p> <p>e) Supervision note must be maintained in the Participant's file for future review. DMHA may request this documentation at any time.</p> | | |

ACTIVITIES ALLOWED

Habilitation services are provided with the goal of enhancing the Participant's level of functioning, quality of life and use of social skills; as well as building Participant and family's strengths, resilience and positive outcomes. This is accomplished through development of the following skills:

- 1) Identification of feelings
- 2) Anger and emotional management
- 3) How to give and receive feedback, criticism, or praise
- 4) Problem-solving and decision making
- 5) Learning to resist negative peer pressure and develop pro-social peer interactions
- 6) Improve communication skills
- 7) Build and promote positive coping skills
- 8) Learn how to have positive interactions with peers and adults
- 9) Habilitation services are provided face-to-face in the Participant's home or other community-based setting based upon the preferences of the Participant/family

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Habilitation Service:

- 1) Duplicative services covered under the Medicaid State Plan.
- 2) Billing for time spent attending the Child and Family Team meetings or completing the Monthly Report.
- 3) Service provided to anyone other than the Participant, when the activity occurs in a group setting.
- 4) Service provided to Participant's family members.
- 5) Service provided in order to give the family/caregiver respite (e.g., such as when the participant may be acting out and the parent wants some relief from care of the Participant).
- 6) Service that is strictly vocational/educational in nature, such as tutoring or any other activity available to the Participant through the local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or covered under the Rehabilitation Act of 1973.
- 7) Activities provided in the service provider's residence.
- 8) Leisure activities that provide a diversion, rather than a therapeutic objective.
- 9) Activities provided with other minors for whom the provider has responsibility, unless the Habilitation activity includes family members of the Participant who are minors.
- 10) Family therapy.
- 11) Interventions provided in a camp setting.

SERVICE DELIVERY STANDARDS

- 1) Need for service must address *Need* identified through the CANS and Child and Family team process, be documented in the POC and authorized by DMHA with a current NOA.
- 2) Service may be provided in the Participant's home, school, or community as described in the POC.
- 3) Intervention must address an identified goal on the Participant's Plan of Care.
- 4) Service is a 1:1 skill building activity that requires engagement with the participant working on an identified need from the POC. Merely being present at a community-based activity with the Participant is not a reason for billing.
- 5) Service provider is responsible to participate in the Child and Family team meetings.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

BILLING INSTRUCTIONS

Refer to Table "*Description of Service Code and Billing*" at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under "*Activities Not Allowed*" for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

SECTION16: RESPITE CARE SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|---|-------------------------|--|--|--|--|
| <i>Respite Routine Hourly</i> | T1005 U7 | Respite care services, up to 15 minutes. | \$4.00 per unit. 1 unit = 15 minutes. | One-to-one; or Multiple persons: When Respite service is being provided to two (2) or more | Billed for service less than 7 hours per day. |
| <i>Respite Routine Daily</i> | S5151 U7 | Unskilled respite care, not hospice; Per diem. | \$100.00 per unit. 1 unit = day. | Participants in the same home at the same time by the same provider, the total units of service for that date of service must be divided accordingly and billed separately for each Participant. | Billed for 7 – 24 hours/per day service. Service not to exceed 14 consecutive days at any one time. |
| <i>Respite Crisis Daily</i> | S5151 U7 U2 | Unskilled respite care, not hospice; Per diem. | \$120.00 per unit. 1 unit = day. | Billing total hours to each participant is considered as <i>Duplicate Billing</i> and is not allowed. (Doing so may constitute fraud.) | Billed for 8 – 24 hours per day service. Service not to exceed 14 consecutive days at any one time. |
| <i>Respite Daily in Medicaid Certified PRTF</i> | S5151 U7 U3 | Unskilled respite care, not hospice; Per diem. | \$321.52** per unit (**Same as Medicaid | | Billing day is same policy as Medicaid PRTFs; census at |

| | | | | | |
|--|--|--|--|--|---|
| | | | PRTF per diem rate) 1 unit = day. | | Midnight. Service not to exceed 14 consecutive days at any one time. |
|--|--|--|--|--|---|

Note: Refer to Manual Section 6 for additional claims and billing information.

RESPITE CARE SERVICE DEFINITION

Respite Care services are provided to participants unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. The fundamental justification for respite care is to provide a break for the caregiver.

The Respite Care Service may be provided in the following manner for planned or routine time frames where the caregiver is aware of needing relief/assistance through the respite care service:

- 1) On an hourly bases, billed less than 7 hours in the same day.
- 2) On a daily basis, as follows:
 - a) Billed for service provided 7 to 24 hours in the same day.
 - b) Respite provided as a daily service cannot exceed fourteen (14) consecutive days at one time.

Crisis Respite Care Service may be provided on an unplanned basis, as an emergency response to a crisis situation in the family, when a caregiver has an unexpected situation requiring assistance in caring for the Participant:

- 1) A crisis situation is one where the Participant's health and welfare would be seriously impacted in the absence of the Crisis Respite Care.
- 2) Crisis Respite is provided on a daily basis, billed 8 to 24 hours in the same day.
- 3) Crisis Respite is not meant to be scheduled to relieve the family when the Participant is in crisis.
- 4) Crisis Respite cannot exceed fourteen (14) consecutive days at one time.

Note: Respite may not be provided as a substitute for regular childcare to allow the parent/guardian to hold a job.

Respite Care services may be provided in the participant's home or private place of residence, or any facility licensed by the Indiana Family and Social Services Administration (FSSA), Division of Family Resources or by the Indiana Department of Child Services (*Refer to Provider qualifications table below*).

Respite services must be provided in the least restrictive environment available and ensure the health and welfare of the participant. A Participant who needs consistent 24-hour supervision with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician or nurse who meets respective licensing or certification requirements of his/her profession in the state of Indiana.

PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|---|---|---|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | Yes Note: <i>Non-accredited Community Service Agencies must receive approval from DMHA, based on licensure of individuals providing services.</i> | Yes Note: Respite Services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite providers who are relatives must meet the following: a) Approved by DMHA as a waiver service provider; b) Selected by the family/child to provide the service; and c) Maintains the qualifications required for Respite service for an Individual Service Provider (Refer to <i>Other Standards</i> below). |
| <i>License</i> | Emergency shelters licensed under 465 IAC 2-10; Special needs foster homes licensed under IC 31-27-4; Therapeutic foster homes licensed under IC 31-27-4; Other child caring institutions licensed under IC 31-27-3; Child Care Centers | Agencies must maintain documentation that individual providing the service meets service standards and requirements listed in Other Standards section below. | NA |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|---|-----------------------|-----------------------------|
| | <p>licensed under IC 12-17.2-4 or Child Care Homes, licensed under IC 12-17.2-5-1 or School Age Child Care Project licensed under IC 12-17-12; or</p> <p>Medicaid certified PRTF under 405 IAC 5-20-3.1 and licensed under 465 IAC 2-11-1 as private secure residential facility.</p> <p>Agencies must maintain documentation that individual providing the service meets service standards and requirements listed in Other Standards section below.</p> | | |
| <i>Certificate</i> | <p>Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1).</p> <p>Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.</p> | NA | NA |
| <i>Other Standards</i> | <p>The DMHA-certified individual providing the service must adhere to the following requirements and standards (Agencies must maintain documentation that individual providing the service meets the following requirements and standards):</p> <ol style="list-style-type: none"> 1) Individual is at least 21 years of age and has a high school diploma, or equivalent. 2) Individual has two (2) years of qualifying experience working with or caring for SED Youth (<i>Refer to SED Experience Requirement subsection in Manual Section 3 for additional information</i>). 3) Individual has completed and submitted proof of the following screens: <ol style="list-style-type: none"> a) Finger-print based national and state criminal history background screen; | | |

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--|---|-----------------------|-----------------------------|
| | b) Local law enforcement screen c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 4) Documentation of safe driving record and maintained vehicle, as well as: a) Current Driver's License; and b) Proof of auto insurance coverage. 5) 4) All approved providers must complete DMHA and OMPP approved training for waiver services. | | |

REQUIREMENTS FOR FAMILY MEMBER AS RESPITE PROVIDER

Respite Services may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Respite providers who are relatives must meet the following:

- 1) Approved by DMHA as a Respite service provider;
- 2) Child and Family Team determine use of family/relative is in Participant's best interests;
- 3) Selected by the family/child to provide the service; and
- 4) Maintains the qualifications required for Respite service (*Refer to Provider qualifications and standards table above*).

Respite Care may not be provided by parents for a participant who is a minor child, or by any relative who is the primary caregiver of the participant.

DMHA will monitor any Respite Care services provided by a relative approved to provide the service to ensure the service is being provided as specified by waiver service policy and procedure, which may include, but is not limited to, an unannounced visit in the home by a waiver service provider during the period the Respite Care service is authorized.

ACTIVITIES ALLOWED

The following activities are eligible for reimbursement under the Respite Care Service:

- 1) Assistance with daily living skills, including assistance with accessing/transporting to/from the community and community activities.
- 2) Assistance with grooming and personal hygiene.
- 3) Meal preparation, serving and cleanup.
- 4) Administration of medications.

- 5) Supervision.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Respite Care Service:

- 1) Duplicative service covered under the Medicaid State Plan.
- 2) Crisis Respite provided as a response to a psychiatric emergency or a child in crisis.
- 3) Billing for time spent attending the Child and Family Team meetings or completing the Monthly Report.
- 4) Provided as a substitute for regular childcare to allow the persons normally providing care to work, attend school or engage in job-related or job search activities.
- 5) For Individual Providers, respite care cannot be provided in the provider's residence.
- 6) For Respite care provided in a licensed foster home, the care must be provided through the local licensed child-placing agency. The licensed child-placing agency must be a DMHA-approved waiver Respite Care service provider.
- 7) No one residing in the participant's residence can be reimbursed for Respite service.
- 8) May not be provided by parents for a participant who is a minor child, or by any relative who is the primary caregiver of the participant.
- 9) Daily twenty-four hour service may not exceed 14 consecutive days at any one time.
- 10) Respite in a PRTF is not allowed as a replacement for the participant's need for admission to a PRTF for treatment. Admission to a PRTF for Respite must be provided within the service definition for Respite.

Note: Respite is not a consequence for a child but a means to provide a break for the caregiver.

SERVICE DELIVERY STANDARDS

- 1) Need for service must address *Need* identified through the CANS and Child and Family team process, be documented in the POC and authorized by DMHA with a current NOA.
- 2) Service may be provided in the Participant's home, school, or community as described in the POC.
- 3) Service provider is responsible to participate in the Child and Family team meetings.
- 4) Must be provided in the least restrictive environment available and ensure the health and welfare of the participant.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 5) A Participant who needs consistent 24-hour supervision with regular monitoring of medications or behavioral symptoms should be placed in a facility under the supervision of a psychologist, psychiatrist, physician, or nurse who meets respective licensing or certification requirements of his/her profession in the state of Indiana (e.g., PRTF respite care).
- 6) May be routinely provided on an hourly basis for less than 7 hours in any one day; or at the daily rate for 7-24 hours.
- 7) Respite may be planned, unplanned or provided due to a crisis.
- 8) Crisis Respite Care is provided for a minimum of 8-24 hours billable at a daily rate.
- 9) Crisis Respite must be reported by the provider to the Wraparound Facilitator within 48 hours of the crisis and the Wraparound Facilitator will determine the need for continued Crisis Respite Care provision.
- 10) 24-hour Respite Care cannot exceed 14 consecutive days.
- 11) Respite service being provided to two (2) or more Participants in the same home, at the same time by the same provider, must total units of service for that date of service and Provider must divide the units accordingly. Services for each Participant are billed separately. Billing total hours to each participant is considered as duplicate billing and is not allowed. (Doing so may constitute fraud.)
 - a) Respite may be provided by any relative related by blood, marriage, or adoption who is not the legal guardian and who does not live in the home with the child. Relatives must be selected by the family and meet all of the qualifications required for individual Respite Care providers.
 - b) Use of family or relative to provide the service is a result of the Child and Family Team determine use of family/relative is in Participant's best interests; and
 - c) A designated service provider on the Child and Family Team will verify that the services are being provided during the scheduled time.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

In addition to standard documentation requirements, document the following in the service notes:

- 1) Primary location of services rendered; and
- 2) The reason for the Respite service.

Note: The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.

BILLING INSTRUCTIONS

Refer to Table "*Description of Service Code and Billing*" at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under "*Activities Not Allowed*" for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

SECTION 17: CONSULTATIVE CLINICAL & THERAPEUTIC SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|--|-------------------------|---|--|--|---|
| <i>Consultative Clinical and Therapeutic Services –</i> Clinical Psychologist or HSPP | H2019 U7 U3 | Therapeutic behavioral services, per 15 minutes. U3 = Clinical Psychologist or HSPP. | \$22.50 per unit 1 unit = 15 minutes. | One-to-one or with Participant and family, as determined by POC. | None |
| <i>Consultative Clinical and Therapeutic Services –</i> Mid-level practitioner | H2019 U7 U4 | Therapeutic behavioral services, per 15 minutes. U4 = Mid-level practitioner. | \$17.50 per unit 1 unit = 15 minutes. | One-to-one or with Participant and family, as determined by POC. | None |

Note: Refer to Manual Section 6 for additional claims and billing information.

CONSULTATIVE CLINICAL AND THERAPEUTIC (CCT) SERVICES DEFINITION

Consultative Clinical and Therapeutic Services are therapeutic behavioral services that are not covered by the State Plan and are necessary to improve the Participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans. Home or community-based consultation activities are provided by professionals in psychology, social work, counseling and behavior management.

This service may be delivered in the Participant's home, in the school, or in the community as described in the Plan of Care to improve consistency across service systems.

Note: *This service may coordinate intervention planning in the school setting, but would not duplicate services that would be provided through an Individual Education Plan (IEP) for children in special education.*

CCT PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|---|--|-----------------------------|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | Yes Note: Non-accredited Community Service Agencies must receive approval from DMHA, based on licensure of individuals providing services. | Yes |
| <i>License</i> | Health Service Provider in Psychology (HSPP) as defined in IC 25-33-1, or in accordance with the provisions of IC 25-23.6, is one of the following: 1) Licensed Marriage and Family Therapist; 2) Licensed Clinical Social Worker; or 3) Licensed Mental Health Counselor. | | |
| <i>Certificate</i> | Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1). Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA. | NA | NA |
| <i>Other Standards</i> | DMHA certified-Individuals providing the service must meet the following, in addition to meeting licensing requirements (Agencies must maintain documentation that individual providing the service meets licensing requirements and the following requirements and standards): 1) Complete and submit proof of the following screens: a. Finger-print based national and state criminal history background screen; b. Local law enforcement screen c. State and local Department of Child Services abuse registry screen; and d. Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 2) Complete DMHA and OMPP approved training and certifications. | | |

ACTIVITIES ALLOWED

The following activities are eligible for reimbursement under the Consultative Clinical and Therapeutic Service:

- 1) Home and community-based therapeutic consultation activities related to the Participant (e.g., POC, diagnosis, history, behaviors, etc.).
- 2) Therapeutic assessment.
- 3) Development of a specialized or supplemental behavior treatment/support plan, in conjunction with Child and Family Team and overall Wrap Plan. Includes monitoring of the participant and other providers in the implementation of the plan developed.
- 4) Training and technical assistance to Caregivers and providers implementing POC or a behavior/support plan in conjunction with POC.
- 5) Coordination of intervention planning in the school setting (that does not duplicate services provided through an Individual Education Plan (IEP) for children in special education).
- 6) Crisis counseling and family counseling in conjunction with a crisis plan or crisis response.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Consultative Clinical and Therapeutic Service:

- 1) Duplicative therapy services covered under the Medicaid State Plan.
- 2) Billing for time spent in Child & Family Team meetings (unless providing a consultation role while in meeting) or completing monthly report.
- 3) Services provided under the Individuals with Disabilities Education Act of 2004 (IDEA) or covered under the Rehabilitation Act of 1973.

SERVICE DELIVERY STANDARDS

- 1) Need for service must address *Need* identified through the CANS and Child and Family team process, be documented in the POC and authorized by DMHA with a current NOA.
- 2) Service may be provided in the Participant's home, school, or community as described in the POC.
- 3) Service provider is responsible to participate in the Child and Family team meetings.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

BILLING INSTRUCTIONS

Refer to Table “*Description of Service Code and Billing*” at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under “*Activities Not Allowed*” for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

SECTION 18: FLEXFUND SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|-------------------|-------------------------|---|------------------|---------------|---|
| <i>Flex Funds</i> | T2025 U7 U2 | Waiver services, NOS (Not otherwise specified). U2 = Miscellaneous non-reoccurring expenses. | 1 unit = \$1.00. | NA | Limited to \$2,000.00 per member/year. Read <i>Allowed</i> and <i>Not Allowed</i> Service definitions below. |

Note: Refer to Manual Section 6 for additional claims and billing information.

FLEX FUNDS SERVICE DEFINITION

Flex funds are utilized to purchase any of a variety of one-time or occasional goods and/or services needed for participants when the goods and/or services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled Participant's Plan of Care.

PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|--|-----------------------|-----------------------------|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | NO | NO |
| <i>License</i> | NA | NA | NA |
| <i>Certificate</i> | Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 | NA | NA |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|--|-----------------------|-----------------------------|
| | IAC 4.1-2-1). Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA. | | |
| <i>Other Standards</i> | Meet qualifications for a Wraparound Facilitation services provider (<i>Refer to Manual Section 13</i>). | NA | NA |

ACTIVITIES ALLOWED

The following may be available under the Flex Funds Service, pending DMHA approval:

- 1) Services or goods directly related to the Participant's approved Plan of Care.
- 2) Prior to funding any good and/or services generally covered by other funding sources, the record must include documentation supporting the unavailability of any other funding source for the goods and/or services in question.
- 3) Flex Funds may be used to purchase bus passes or alternate methods of public transportation to enable participants and their families to gain access to approved PRTF Waiver services and other community services, activities and resources.

Note: Flex Funds are only to be used if reasonable efforts to secure funding from other community sources have been explored and is not available. Documentation in the clinical record regarding the unavailability of any other funding source for the goods and/or services will be required.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Flex Funds Service:

- 1) Duplicative services covered under the Medicaid State Plan.
- 2) Purchase of bus passes or alternate methods of transportation that duplicate services delivered under Transportation services in the waiver and/or Medicaid State Plan services (if applicable). Flex funds may not be used for purposes that are intended as a diversion and do not have a therapeutic objective.
- 3) Purchase of goods or services not specifically related to the approved the Plan of Care are not funded. (e.g., if the Plan of Care authorizes flex Funds for school supplies, that funding cannot be used to purchase any other items, such as groceries). If the Participant requires other goods or services, these must be approved prior to the purchase of those goods or services.

- 4) Purchase of goods or services covered by any other funding source.
- 5) Funding used for provider expenses.
- 6) Purchases will not supplant normal family obligations (e.g., room and board, rent, utility bills, groceries, school clothing, etc.).
- 7) Purchase of meals when taking a Participant out in the community.
- 8) Purchase of non-recurring set-up expenses (such as furniture and bedding or clothing).
- 9) Combining purchases for two (2) or more Participants from one participant's funding source. Flex Funds services must be specific to services authorized on the individual Participant's Plan of Care. (e.g., two Participants reside in the same home and both require school supplies--these goods must be purchased on separate receipts and billed separately to each participant as authorized on each individual Participant's Plan of Care.)

SERVICE DELIVERY STANDARDS

- 1) The use of flex funds on an expenditure must be tied directly to a *Need* documented on the Plan of Care and CANS assessment, supported by a rationale(s) as to how the expenditure will assist the Participant in remaining in the home and/or community; and must be related to one or more of the following outcomes:
 - a) Success in school;
 - b) Living at the person's own home or with family;
 - c) Development and maintenance of personally satisfying relationships;
 - d) Prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation; and/or
 - e) Becoming or remaining a stable and productive member of the community.
- 2) Expenditure must be authorized by DMHA with a current NOA.
- 3) WF is required to provide documentation of three (3) sources that were explored/exhausted before requesting Flex Fund expenditure.
- 4) The documentation must also include the wraparound team determination that the expenditure is appropriate and needed in order to achieve the treatment goals and that the expenditure will not supplant normal family obligations.
- 5) Documentation must also be included in the clinical record regarding the unavailability of other funding source(s) for the goods and/or services, the necessity of the expenditure and the outcomes affected by the expenditure.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

In addition to standard documentation requirements, the following documentation will be required in the service record/notes:

Receipts (or copies) for services, payments, or goods must be included in the case file. If no receipt is available, the Wraparound Facilitator and parent or legal guardian must sign a statement documenting that the claimed services or goods were delivered and the cost of the services or goods.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

BILLING INSTRUCTIONS

Refer to Table “*Description of Service Code and Billing*” at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information.

Providers cannot bill for any activity listed above under “*Activities Not Allowed*” for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

Note: Claims for flex funds will be submitted through the regular claims process.

SECTION 19: NON-MEDICAL TRANSPORTATION SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|-----------------------------------|-------------------------|---|--|---------------|--|
| <i>Non-Medical Transportation</i> | T2003 U7 U1 | Non-emergency transportation; encounter/trip. U1 = round trip. | \$20.00 per unit 1 unit = round trip. | | No limit on number of daily trips. Annual limit of \$1,000.00/per year. |

Note: Refer to Manual Section 6 for additional claims and billing information.

NON-MEDICAL TRANSPORTATION SERVICES DEFINITION

Transportation services are available to enable waiver Participants and their families to gain access to waiver services and other community services, activities, and resources, as specified in the Plan of Care. Whenever possible, family, friends, neighbors, or community agencies, who can provide this service at no charge, should be utilized.

Note: This waiver service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) and does not replace medical transportation.

PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|-------------------|---|--|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | Yes Note: Non-accredited Community Service Agencies must receive approval from DMHA, based on qualifications of individuals providing | Yes Non-Medical Transportation Services may be provided by a custodial parent, foster parent, or legal guardian if the Treatment Team |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|--------------------|--|-----------------------|--|
| | | services. | <p>determines that no other providers or resources are available for this service. When custodial parents/foster parent/legal guardians are utilized for Non-Medical Transportation, that individual must:</p> <ol style="list-style-type: none"> 1) Be approved by DMHA as a PRTF Waiver provider; 2) Be selected by the family/child to provide the service; 3) Child and Family Team determined that service provided by individual is in the Participant's best interests; and 4) Maintain the qualifications required for this service as an Individual Provider (Refer to <i>Other Standards</i> below). |
| <i>License</i> | Individual providing transportation must have a valid driver's license; Do not need to be licensed as a Medicaid Transportation Driver. | | |
| <i>Certificate</i> | <p>Community Mental Health Centers certified as a Community Mental Health Center by the DMHA (440 IAC 4.1-2-1).</p> <p>Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.</p> | NA | NA |

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|--|-----------------------|-----------------------------|
| <i>Other Standards</i> | <p>DMHA-certified Individual must meet the following additional service requirements and standard (Agencies must maintain documentation that individual providing the service meets the additional following requirements and standards):</p> <ol style="list-style-type: none"> 1) Complete and submit proof of the following screens for individuals who are not the custodial parent/legal guardian/foster parent: <ol style="list-style-type: none"> a) Finger-print based national and state criminal history background screen; b) Local law enforcement screen; c) State and local Department of Child Services abuse registry screen; and d) Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 2) Complete DMHA and OMPP approved training and certifications. 3) Documentation of safe driving record and maintained vehicle, as well as: <ol style="list-style-type: none"> a) Current Driver's License; and b) Proof of auto insurance coverage. | | |

ACTIVITIES ALLOWED

The following activities are eligible for reimbursement under the Non-Medical Transportation Service. Transportation service is allowed:

- 1) To enable Participant/family to gain access to waiver services and other community services;
- 2) To and from school, if the school does not provide transportation;
- 3) To community resources;
- 4) To an approved after school or week-end therapeutic activity (e.g., summer camp), and other similar services or activities.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Non-Medical Transportation Service:

- 1) Duplicative service covered under the Medicaid State Plan.
- 2) Billing for time spent attending the Child and Family Team meetings or completing the Monthly Report.
- 3) Transportation for medical purposes required under 42 CFR 431.53 and transportation services provided under the Medicaid State Plan at 42 CFR 440.170(a) (as applicable).
- 4) Transportation for any reason not directly tied to the participant's approved Plan of Care;
- 5) Transportation that can be provided by family, friends, neighbors or other community resources, at no cost to the Waiver;
- 6) Transportation for activities that are recreational or provide a diversion, rather than a therapeutic objective;
- 7) Transportation that duplicates time billed for Habilitation Service activities with the Participant;

- 8) Transportation that is for the primary benefit of the Transportation provider, such as running non-waiver related errands with the Participant.

SERVICE DELIVERY STANDARDS

- 1) Need for service must address *Need* identified through the CANS and Child and Family team process, be documented in the POC and authorized by DMHA with a current NOA.
- 2) Transportation services under the PRTF Waiver are offered in accordance with the Participant's Plan of Care. Federal financial participation is available for the cost of transportation to a training event or conference.
- 3) Use of family or relative to provide the service is a result of the Child and Family Team determination that use of family/relative is in Participant's best interests.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report.

In addition to standard documentation requirements, the service provider must also ensure the service note includes:

- 1) Destination information; and
- 2) A statement regarding the unavailability of other transportation resources.

For Non-Medical Transportation services provided by a family member, the following additional documentation requirements apply:

- 1) All Non-Medical Transportation Service provided must be documented by date, time, duration, purpose and the documentation must be submitted to the Wraparound Facilitator.
- 2) Documentation required in the record that no other transportation resources available and that the provision of service by family member is in the best interests of the Participant.
- 3) The Wraparound Facilitator and/or Wraparound Technician verifies monthly reports submitted against the approved Non-Medical Transportation amount listed in the Notice of Action.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

BILLING INSTRUCTIONS

Refer to Table "*Description of Service Code and Billing*" at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under "*Activities Not Allowed*" for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions

SECTION 20: TRAINING & SUPPORT FOR UNPAID CAREGIVER SERVICE

DESCRIPTION OF SERVICE CODE & BILLING INFORMATION

| Service | HCPCS Code and Modifier | HCPCS Code Description | Unit and Rate | Service Ratio | Limitations (Amount/ Duration/ Frequency) |
|---|-------------------------|--|--|---|---|
| <i>Training and Support for Unpaid Caregiver - Hourly</i> | H2015 U7 U1 | Comprehensive community support services, per 15 minutes. U1= Individual training sessions. | \$15.00 per unit. 1 unit = 15 minutes; individual training session. | One-to-one | Limited to 8 units/ per day (2 hours). No Annual Limit. |
| <i>Training and Support for Unpaid Caregiver – Non-Hourly/Family</i> | S5111 U7 | Home care training for family (caregiver) | 1 unit = registration, fees and/or supplies. | Group activities (conference, classes, etc.) are based on the cost of the activity. | \$500 max/per unit. Total of this service, plus S5116, limited to \$500 per year. Reimbursement is not available for the costs of travel, meals, and overnight lodging. |
| <i>Training and Support for Unpaid Caregiver – Non-Hourly/Non-Family</i> | S5116 U7 | Home care training for non-family (caregiver) | 1 unit = registration, fees and/or supplies. | Group activities (conference, classes, etc.) are based on the cost of the activity. | \$500 max/per unit. Total of this service, plus S5111, limited to \$500 per year. Reimbursement is not available for the costs of travel, meals, and overnight lodging. |

Note: Refer to Manual Section 6 for additional claims and billing information.

TRAINING AND SUPPORT FOR UNPAID CAREGIVER SERVICE DEFINITION

Training and Support for Unpaid Caregivers is a service provided for an individual who is providing unpaid support, training, companionship or supervision for the Participant.

The intent of the service is to provide education and supports to the caregiver that preserves the family unit and increases confidence, stamina and empowerment.

Training and support activities, and the providers selected for these activities, are based on the family/caregiver's unique needs and are identified in the POC.

Provision of service is:

- 1) Available for non-hourly Training and Support for Unpaid Caregivers for the costs of registration/conference training fees, books and supplies associated with the training and support needs, as documented on the participant's POC; and provided by the following types of resources:
 - a) Non-profit, civic, faith-based, professional, commercial, or government agencies and organizations.
 - b) Community colleges, vocational schools or universities.
 - c) Lecture series, workshops, conferences, seminars.
 - d) On-line training programs.
 - e) Community Mental Health Centers.
 - f) Other qualified community service agencies.
- 2) Service may also be provided on an hourly schedule for one-on-one training by an approved waiver service provider (Refer to *Provider Qualifications and Standards* below).

PROVIDER QUALIFICATIONS AND STANDARDS

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|---|--|---|---|
| <i>Provider Type Eligible to Bill for Service (Yes or No)</i> | Yes | Yes Note: Non-accredited Community Service Agencies must receive approval from DMHA, based on qualifications of the individuals providing services. | Yes Note: The individual providing the service must reside within a one county area from the youth's place of residence; and must meet the Other Standards below. |
| <i>License</i> | NA | NA | NA |
| <i>Certificate</i> | Community Mental Health Centers certified as a | Wraparound Facilitation provider agency must be | NA |

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

| | Accredited Agency | Non-Accredited Agency | Individual Service Provider |
|------------------------|---|--|-----------------------------|
| | <p>Community Mental Health Center by the DMHA (440 IAC 4.1-2-1).</p> <p>Community Service Agencies accredited by AAAHC, COA, URAC, CARF, ACA, JCAHO, or NCQA.</p> | <p>approved by DMHA to provide Wraparound Facilitation.</p> <p>Other Community Service Agencies that have not been approved as a Wraparound Facilitation provider must:</p> <ol style="list-style-type: none"> 1) Have a current contract with systems of care agencies; or 2) Be enrolled as a waiver provider approved by the Division of Disability and Rehabilitative Services to provide Family and Caregiver Training under Indiana's Home and Community-Based Services Waivers. | |
| <i>Other Standards</i> | <p>The individuals providing the service must meet the following service provider qualifications (Agencies must maintain documentation that individual providing the service meets the following requirements and standards):</p> <ol style="list-style-type: none"> 1) At least 21 years of age; and High school diploma, or equivalent; 2) Resident of the same SOC region as the participant; 3) Individual has two (2) years of qualifying experience working with or caring for SED Youth (<i>Refer to SED Experience Requirement subsection in Manual Section 3 for additional information</i>). 4) Complete and submit proof of the following screens for individual providing the service: <ol style="list-style-type: none"> 1) Finger-print based national and state criminal history background screen; 2) Local law enforcement screen; 3) State and local Department of Child Services abuse registry screen; and 4) Five-panel drug screen, or Agency meets the same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1). 5) Complete DMHA and OMPP approved training and certifications. | | |

ACTIVITIES ALLOWED

Training and Support Services allowed may include, but are not limited to, teaching the following:

- 1) Practical living and decision-making skills.
- 2) Child development parenting skills.
- 3) Home management skills.
- 4) Use of community resources and development of informal supports.
- 5) Conflict resolution.
- 6) Coping skills.
- 7) Gaining an understanding of the Participant's mental health needs.
- 8) Learning communication and crisis de-escalation skills geared for working with Participant's mental health and behavioral needs.

ACTIVITIES NOT ALLOWED

The following activities are not eligible for reimbursement under the Habilitation Service:

- 1) Duplicative services covered under the Medicaid State Plan.
- 2) Billing for time spent attending the Child and Family Team meetings or completing the Monthly Report.
- 3) The cost of travel, meals and overnight lodging.

SERVICE DELIVERY STANDARDS

- 1) For purposes of this service, "Unpaid Caregiver" is defined as any person, family member, neighbor, friend, coworker, or companion who provides uncompensated care, training, guidance, companionship, or support to a PRTF Waiver participant.
- 2) Need for service must address *Need* identified through the CANS and Child and Family team process; be documented in the POC and authorized by DMHA with a current NOA.
- 3) Service provider providing the training and support services must be documented in the POC and authorized by DMHA with a current NOA.
- 4) Service may be provided in the Participant's home, school, or community as described in the POC.
- 5) Service provider (hourly service provider) is responsible to Participate in the Child and Family team meetings when providing support to the unpaid caregiver within the activities included in the service definition as approved by the Wraparound Facilitator.

DOCUMENTATION REQUIREMENTS

Refer to Manual *Section 5* for *Documentation Standards and Guidelines*. Service provider is responsible for Service Notes and the Monthly Status Report. In addition to standard documentation requirements, the following applies for this service:

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

- 1) Non-hourly Training and Support requires receipt of payment for the activity (class/conference registration, fees, supplies, etc.) and proof of participation in the training and Support activity if payment is made directly to the individual/family.

BILLING INSTRUCTIONS

Refer to Table “*Description of Service Code and Billing*” at beginning of this Service Section for HCPCS (procedure) code; code modifier; code description; billing unit and unit rate information. Providers cannot bill for any activity listed above under “*Activities Not Allowed*” for this service. Refer to Manual *Section 6* for detailed *Claims & Billing* instructions.

Note: *The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the waiver service billed.*

SECTION 21: CRITICAL EVENTS & INCIDENTS

OVERVIEW OF EXPECTATIONS

Indiana state law, Indiana Code (IC) 31-33 et al, requires reporting of suspected child abuse or neglect to the Indiana Department of Child Services (DCS). DCS is the single state agency responsible for administering the federal Child Abuse Prevention and Treatment Act under 42 U.S.C. 5106 et seq.

IC 31-33-5 requires any individual who has reason to believe that a child is a victim of child abuse or neglect to make a report. Staff of a medical or other public or private institution, school, facility, or agency including DMHA and its providers, are required to notify the individual in charge of the institution, school, facility, or agency who shall report or cause a report to be made to the state child protection agency. Reports are to be made immediately. Reporting may be done in person, by phone, or in writing. A report can be filed with the county office of child services or by calling 1-800-800-5556.

Indiana law further defines conditions under which a child may be determined to be “a child in need of services” (CHINS). Under IC 31-34 abuse, neglect and exploitation are defined as: the child's physical or mental health condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent/guardian/custodian to supply the child with necessary food, clothing, shelter, medical care, education, or supervision; the child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent/guardian/custodian; the child's parent/guardian/custodian allows the child to participate in an obscene performance; or the child's parent/guardian/custodian allows the child to commit a sex offense. If the child is in imminent danger, an investigation is immediately launched by the local DCS office. Time frames for investigation are determined by the DCS.

The Division of Mental Health and Addiction (DMHA) requires that all providers comply with state law and notify DCS of alleged child abuse, neglect or exploitation within 24 hours of the event.

Providers are also required to report to DMHA sentinel and other critical incidents within 24 hours of the incident using an incident report form developed specifically for this Waiver.

Reportable events include:

- 1) A sentinel event is a serious and undesirable occurrence involving the loss of life, suicide (Defined as the act or an instance of taking one's own life voluntarily and intentionally), limb or gross motor function for a consumer or individual providing waiver services.
- 2) Other critical events, with required reporting include:
 - a) Suicide attempt.
 - b) Seclusion (Defined as the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving).
 - c) Use of restraints (Defined as any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body).
 - d) Medication errors that occur when the child is not in the home of a parent/guardian/or other legally responsible adult.
 - e) Violation of rights (Defined as an act that disregards an agreement or a right) related to the Waiver.

- f) A report to Child Protective Services.
- g) Law Enforcement report involving a child participating in Waiver services.

All service providers are required to adhere to DMHA/OMPP's expectations regarding protecting the health and welfare of each Participant served. It is expected that service providers will adhere to the Incident Reporting Policy:

INCIDENT REPORTING POLICY

To provide a mechanism for reporting and responding to critical and sentinel incidents occurring in connection with a Division of Mental Health and Addiction (DMHA) Waiver services program, participant, family, service provider, services and/or service delivery system, the following policy is in effect:

- 1) Completion of an *Incident Initial Report* form is required in either of the following situations:
 - a) *Sentinel Event*- This type of event is defined as a serious and undesirable occurrence involving the loss of life, suicide (Defined as the act or an instance of taking one's own life voluntarily and intentionally), limb or gross motor function for a participant or individual providing services for a program participant.
 - b) *Critical Incident*- Examples of this type of event include:
 - i) Use of restraint
 - ii) Elopement
 - iii) Medication error (pertains to errors that occur when participant is not in the home or care of the parent/caregiver)
 - iv) Serious injury
 - v) Suicide attempt
 - vi) Seclusion
 - vii) Violation of rights
 - viii) Incident requiring police or Child Protective Services (CPS) response/involvement
 - ix) Neglect, abuse or exploitation
- 2) If a critical or sentinel event occurs, the individual witnessing or required to report the incident must completely fill-out and return the Incident Initial Report.
- 3) Mandatory reporting timeframes are as follows:
 - a) *Sentinel Event*: Wraparound Facilitator and any other wraparound service provider witnessing or becoming aware of the event must complete and submit an *Incident Initial Report* to DMHA **within 24 hours of the event, or becoming aware of the event.**
 - b) *Critical Incident*: Wraparound Facilitator and any other wraparound service provider witnessing or becoming aware of the event must complete and submit an *Incident Initial Report* to DMHA **within 72 hours of the event, or becoming aware of the event.**
- 4) In the event of a report of neglect, abuse and/or exploitation, a report must also be completed and submitted to CPS.
- 5) The *Incident Initial Report* is submitted to DMHA via a secure fax line number: (317) 233-1986. Fax line is accessible 24 hours a day/7-days a week.

SECTION 22: GRIEVANCE OR COMPLAINTS

GRIEVANCE OR COMPLAINT REPORTING POLICY

Objective:

To provide Participants and families a formal process to ensure they can voice concerns, complaints and grievances regarding the PRTF Transition Waiver program to the Division of Mental Health and Addiction (DMHA) for review and resolution.

Policy:

- 1) When a program participant or family member wishes to share a concern, complaint or grievance with DMHA, they may do so by completing and submitting a *Formal Concern or Complaint* form, with the following information:
 - a) Date of filing form.
 - b) Name of person completing the form (This information may be omitted if report is being made anonymously).
 - c) Contact information (email or phone)—if the person filing the form wishes a DMHA staff member to follow-up with them regarding resolution to the complaint/concern/grievance.
 - d) Name of program participant.
 - e) Description of the concern, complaint or grievance.
- 2) A DMHA staff member will follow-up with the individual filing the *Formal Concern or Complaint* form within 72 working hours from the date the completed form is received.
- 3) DMHA maintains on-site documentation of all received *Formal Concern or Complaint* forms, including follow-up actions and resolution.
- 4) Additional resources available to participants and family members wishing to file a formal complaint or concern includes the following:
 - a) Participant's Wraparound Facilitator
 - b) DMHA Website— Visit the following link for a copy of the Grievance or Complaint form or more information: <http://www.in.gov/fssa/dmha/6643.htm>.
 - c) DMHA Office of Consumer and Family Affairs—Visit the website for more information: <http://www.in.gov/fssa/dmha/4339.htm>.

SECTION 23: GLOSSARY

Abbreviation/Acronym Definitions:

837P: Electronic claim form for submission of authorized Medicaid waiver services rendered by an enrolled Medicaid waiver service provider.

CANS: The Child and Adolescent Needs and Strengths assessment tool is used to assess the child/youth's and the caregiver's needs and strengths. The CANS assessment ratings are submitted to DMHA's DARMHA (Refer to definition below) to make decisions about appropriate intensity of needed services and the required PRTF level of care eligibility for waiver services.

CA-PRTF: The Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant was Indiana's five-year grant that provided intensive, home and community-based wraparound services for qualified youth and families from October 1, 2007 through September 30, 2012. (Eligible Participants with an open POC in effect as of September 30, 2012 were automatically transitioned to the new PRTF Transition Waiver October 1, 2012 for continued services.)

CCB: The Cost Comparison Budget is the electronic format in the DMHA database (currently INsite) documenting all authorized waiver services, units of service, the allocation of funding for the specified services and the provider(s) of each service that are included on a Participant's Plan of Care (POC). This format is used as a part of the process for the authorization of waiver services and issuance of the Notice of Action (NOA).

CMHC: Acronym for the Community Mental Health Center. For purposes of this Waiver, CMHCs are certified as such by the DMHA under 440 IAC 4.1-2-1.

CMS: The federal Centers for Medicare and Medicaid Services, which has authority over all Medicaid Waiver programs in each State, including the PRTF Transition Waiver. CMS must approve the initial waiver program request and all subsequent program amendments and funding.

CMS-1500: The CMS authorized claim form used to submit paper claims to the Medicaid Fiscal Contractor for reimbursement of prior authorized and rendered waiver services.

CSA: An acronym for Community Service Agency. For purposes of this waiver the CSA may be either accredited or non-accredited, but both must be approved by the DMHA to be enrolled as a waiver service provider.

CSL: The Indiana Consumer Service Line is a toll-free phone line for consumers to share compliments, questions and concerns regarding services, treatments, procedures, rights and policies. The phone line is available and staffed by a DMHA contractor Monday – Friday 8:30am – 5:00pm.

CPR: Cardiopulmonary resuscitation. As defined by each PRTF Transition Waiver service qualifications, CPR certification must be maintained to provide services.

DCS: Department of Child Services - DCS protects children from abuse and neglect by partnering with families and communities to provide safe, nurturing, and stable homes. DCS includes Child Protective Services, Child Support, Foster Care and Adoption services.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

DEW: The Data Entry Worksheet is used by the Wraparound Facilitator to enter information in the DMHA database (INsite) regarding a change in eligibility status for waiver services reimbursed through the Medicaid IndianaAIM system.

DFR: The Division of Family Resources, within the Family Social Service Administration (FSSA) is responsible for the processing of applications and approval of eligibility for Medicaid, TANF (cash assistance), child care assistance, food stamps, and employment and training services for low-income clients.

DRA: The Deficit Reduction Act of 2005 – the DRA authorized the original 5-year CA-PRTF Demonstration Grant. At the expiration of the Grant the DRA also authorized the continuation of services under a new HCBS Waiver (Indiana's PRTF Transition Waiver) to eligible Participants on the Grant as of September 30, 2012.

DMHA: Indiana Department of Mental Health and Addiction within the Family and Social Services Administration (FSSA) is responsible for the daily operation of the Waiver.

FSSA: The Indiana Family and Social Services Administration was established by the General Assembly in 1991 to consolidate and better integrate the delivery of human services by State government. FSSA includes the Division of Aging (DA), the Division of Disability and Rehabilitative Services (DDRS), the Division of Family Resources (DFR), the Division of Mental Health and Addiction (DMHA), and the Office of Medicaid Policy and Planning (OMPP).

HCBS: Home and Community-Based Services is a system of services provided to someone residing in a community setting, as opposed to an institutional or residential setting. For Medicaid purposes, "HCBS" generally refers to HCBS Waiver programs authorized by CMS under §1915(c) of the Social Security Act.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 mandated requirements for the adoption of national standards for health care, including the protection of health information and standard unique identifiers for all health care providers and coding of health care services for approving, billing, reimbursing and tracking.

HP: Previously named Electronic Data System (EDS), HP is the Indiana Medicaid Fiscal Agent responsible for maintaining IndianaAIM (Indiana's Medicaid Management Information System – MMIS) data base for all Medicaid participants, provider enrollment, authorized Medicaid services, Medicaid claims processing and reimbursement for eligible Medicaid providers. This includes all approved waiver participants, authorized services and enrolled providers of waiver services. HP assigns all Medicaid provider numbers ("LPI") required for reimbursement of all Medicaid claims. HP maintains the Indiana Health Coverage Programs (IHCP) Provider Manual for all Medicaid providers.

IAC: The Indiana Administrative Code is Indiana's state policy and procedures.

IC: The Indiana Code is Indiana's state statutes that govern the Indiana Administrative Code (IAC).

IDEA: The Individuals with Disabilities Education Act (1997) under the U.S. Department of Education is the federal law ensuring services to eligible children with disabilities throughout the nation. IDEA governs how states and public agencies provide early intervention, special education and related services. IDEA Part B includes special education and related services to children and youth ages 3 to 21.

IDIEA: The Individuals with Disabilities Improvement Education Act (2004) was re-authored and renamed to amend the 1997 Act).

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

IEP: The Individualized Education Program (2004, updated under IDEIA) addresses a student's current academic and functional performance levels and annual academic and functional goals.

IHCP: Indiana Health Coverage Programs within OMPP. (Refer to MCO/MCE and OMPP below.)

IndianaAIM: Medicaid Management Information System (MMIS) is called the Advanced Information System (AIM), and is run by a contractor, HP. See HP above for additional information.

INsite: FSSA's electronic management system that processes and tracks information relating to waiver services, including: demographic information; LOC and eligibility information; documentation of choice; waiver providers; pick lists; POC/CCBs; costs; approvals and denials. The system is used by the Wraparound Facilitator to manage the POC/CCB and generate and store the NOAs. After the Wraparound Facilitator enters the approved POC/CCB in INsite, INsite interfaces with the Medicaid Management Information System to authorize the waiver services for Medicaid reimbursement.

LOC: Level of Care is one of the federal eligibility requirements for the PRTF Transition Waiver program. Continued eligibility for the waiver is dependent upon Participant meeting the specific LOC documented in the CMS approved waiver, which is equivalent to the LOC of a Medicaid enrolled PRTF (RE: "PRTF" below).

LPI: Legacy Provider Identifier is the number is assigned by the Medicaid Fiscal Contractor during the provider enrollment process. All Medicaid enrolled providers, including service providers, are assigned an LPI provider number for submission of all claims for Medicaid reimbursement.

MCO/MCE: The acronym for a Managed Care Organization/Managed Care Entity. Indiana Medicaid has contractual agreements for managed health care plans under Indiana's Health Coverage Programs (IHCP). There are two managed health care programs serving different populations: Hoosier Healthwise and Care Select. Please note: individuals receiving PRTF Transition Waiver services cannot be served in a Medicaid managed care program.

MMIS: The acronym for Indiana's Medicaid Management Information System. See HP above for additional information.

NOA: Notice of Action (State Form-HCBS Form 5) is the written notice given to each waiver participant for any action that will affect his/her waiver benefits. The NOA includes:

- 1) DMHA actions to approve or deny a Participant's waiver services;
- 2) Authorized waiver benefits;
- 3) Subsequent changes to increase, reduce or terminate, any or all waiver services;
- 4) Effective dates and reasons for the action(s) taken; and
- 5) Participant's Appeal Rights.

NPI: The National Provider Identifier is the HIPAA mandated standard unique identifier for all health care providers. Unique NPI numbers are assigned by application to the National Plan and Provider Enumeration System which collects identifying information on health care providers. **Note:** an assigned NPI is not needed for waiver service providers who do not perform healthcare services. (Waiver service providers are encouraged to submit waiver claims using their LPI.)

OBHP: The acronym for a service provider that qualifies as an Other Behavioral Health Professional, as defined in 405 IAC 5-21.5.

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

OMPP: Office of Medicaid Policy and Planning within the Family and Social Services Administration. The OMPP administers the Indiana Health Coverage Programs (IHCP) in accordance with federal and state requirements, which includes responsibility for oversight of the waiver.

PA: For purposes of the waiver, this refers the prior authorization of PRTF Transition Waiver services through the CCB and NOA processes. PA also refers to the general prior authorization required for the provision of specified Medicaid-funded state plan services.

POC: The Plan of Care is a written document that is developed by the Child and Family Team, with active input and participation from the Participant/family. The POC is the blending of team member perspectives, mandates and resources; and is based on Participant and family strengths, needs, preferences, values and culture.

PRTF: Acronym for a Psychiatric Residential Treatment Facility. Effective January 1, 2004, a PRTF in Indiana is licensed under 465 Indiana Administrative Code 2-11 as a private, secure residential care institution and must be accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); American Osteopathic Association (AOA); or the Council on Accreditation of Services for Families and Children (COA). PRTFs receive reimbursement to provide prior authorized institutional care to children with a severe emotional disturbance who are under the age of 21 (or continued services to children under age 22 who were in the PRTF immediately prior to their 21st birthday).

QIS: DMHA contracts with Quality Improvement Specialists to engage in activities meant to ensure quality program outcomes and support to service providers and participant/families. (RE: Manual Section 7.)

RID: Recipient Identification Number, which is the number used to identify the individual for Indiana's Health Coverage Programs for Medicaid eligibility for services, tracking and claims processing of eligible services. This includes the waiver program.

SED: Serious Emotional Disturbance as defined in 440 IAC 8-2-4 (Note, the waiver covers SED individuals only from age of 6 through 17.)

SMI: Serious Mental Illness as defined in 440 IAC 8-2-2 (Note, the waiver covers SMI individuals only between the ages of 18 – 20)

SOC: A System of Care is a comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of youth and their families. SOC includes the concept for care delivery that is: family-driven and youth guided; individualized and community-based; and culturally and linguistically competent.

SUR: Waiver auditing function is incorporated into the Surveillance Utilization Review functions of the contract between the Medicaid agency and the SUR Contractor. Indiana's quality management process includes SUR auditing of services rendered and paid under the PRTF Transition Waiver. (RE: Manual Section 8 on Utilization Review and Quality Improvement.)

WF: The acronym for a Wraparound Facilitator who provides the Wraparound Facilitation service for waiver Participants. Wraparound Facilitation is a comprehensive service comprised of a variety of specific tasks and activities designed to carry out the wraparound process.

WFI 4.0: The Wraparound Fidelity Index tool is used to measure fidelity to the wraparound process as established by the National Wraparound Initiative, which defines the 4 phases and 10 guiding principles

PRTF TRANSITION WAIVER: PROVIDER POLICY & PROCEDURE MANUAL

used for Wraparound services as a process of individualized care planning for youth with complex needs and their families.

YSS: Youth Services Survey is the consumer satisfaction survey used for waiver evaluation purposes.

YSSF: Youth Services Survey for Families is the consumer satisfaction survey used for waiver evaluation purposes.